

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

The Perceptions and Socio-Cultural Beliefs of Xhosa Speaking People in Relation to
Perinatal Distress

Jabulisile C. N. Chonco

A dissertation submitted in partial fulfilment of the requirements for the degree of
Masters of Arts in Clinical Psychology

Department of Psychology

University of Cape Town

2007

Declaration

I confirm that this is my own work and the use of all material from other sources has been properly and fully acknowledged.

Jabulisile Chonco

University of Cape Town

Abstract

The current study aims to explore the perceptions and socio-cultural beliefs amongst Xhosa speaking people in relation to perinatal distress. A sample of 20 participants was selected in Cape Town. A grounded theory method of study was used to develop hypotheses relating to perinatal distress. Semi-structured interviews were conducted. The interview material was analysed using the grounded theory method. The findings of the study indicated that within the Xhosa speaking community distress during pregnancy, childbirth and the postpartum period appears to be understood in relation to unavailability of resources such as finance and partner support. The overall conclusion was that in the presence of these resources, a woman might not experience distress.

ACKNOWLEDGEMENTS

I would like to thank the following people for the invaluable contributions to this study:

My supervisor, Dr. Mark Tomlinson for his insightful comments and continued support.

The participants in the study, who were open in sharing their experiences, thoughts and feelings.

My colleagues in the Department of Correctional Services who allowed me the time and space to work on my study, and who offered constant support and encouragement.

My loving son, family and friends for their love, unconditional support and encouragement when I had self doubt.

To Nomakhaya Feni for her consistent support in obtaining the participants.

TABLE OF CONTENTS

Declaration.....	i
Abstract.....	ii
Acknowledgements.....	iii
CHAPTER 1: INTRODUCTION.....	1
CHAPTER 2: LITERATURE REVIEW.....	4
2.1. Culture and the childbearing process.....	4
2.1.1. The influence of culture in the childbearing process.....	5
2.2. The childbearing process	6
2.2.1. The antenatal period.....	6
2.2.2. Childbirth.....	7
2.3. Psychological aspects of childbearing.....	8
2.3.1. Overview of childbearing distress.....	8
2.3.2. Postpartum depression.....	8
2.4. The childbearing process in developed countries.....	10
2.4.1. Socio-cultural background.....	10
2.4.2. The role of social support during the childbearing process.....	11
2.5. Childbearing process in Africa.....	12
2.5.1. The socio cultural background.....	12
2.5.2. The role of traditional birth attendants.....	13
2.5.3. The role of social support.....	14
2.5.4. The use of traditional medicine.....	14

2.6. The childbearing process among Africans in South Africa.....	15
2.6.1. Traditional childbearing practices.....	15
2.6.1.1. Pregnancy.....	15
2.6.1.2. Labour.....	17
2.6.1.3. Postpartum.....	17
2.6.2. Current childbearing practices among Africans in South Africa.....	18
2.6.2.1. Changes in practice.....	18
2.6.2.2. The use of traditional medicine.....	20
2.7. Perceptions of health and illness.....	21
2.7.1. Definition of health by the World Health Organisation.....	21
2.7.2. The South African health context.....	21
2.7.3. Perceptions of health and illness within the Xhosa community.....	23
2.7.3.1. Nature of illness.....	23
2.7.3.2. Perceptions of mental illness.....	24
2.8. Aims of the study.....	26
CHAPTER 3: METHODOLOGY.....	27
3.1. Grounded theory.....	27
3.1.1. Data collection, analysing and sampling using grounded theory.....	28
3.2. Participants.....	29
3.3. The interview structure.....	30
3.4. Setting.....	31
3.5. Ethical permission.....	34
3.6. The interview.....	34

3.7. The Analysis process.....	35
3.7.1. Developing codes and categories.....	35
3.7.2. Developing higher order categories.....	35
3.7.3. Development of themes.....	36
3.7.4. Development of hypothesis.....	36
CHAPTER 4: RESULTS AND DISCUSSION.....	38
4.1. Themes.....	45
4.1.1. Childbearing process as a sacred life task.....	45
4.1.1.1. Traditional medicine.....	48
4.1.2. Childbearing as a process of transformation.....	49
4.1.3. Planning and readiness.....	50
4.1.4. A shift from traditional values.....	51
4.1.5. Communication task during the childbearing process.....	56
4.1.6. Conflicting practices.....	57
4.1.7. The positive impact of support.....	60
4.1.8. Paternal involvement.....	61
4.1.9. Distress as a source of community failure.....	63
4.2. Hypothesis.....	65
4.2.1. Hypotheses 1.....	65
4.2.2. Hypotheses 2.....	67
4.2.3. Hypotheses 3.....	68

CHAPTER 5: CONCLUSION.....	70
5.1. Conclusion.....	70
5.2. Limitations of the study.....	75
5.2.1. The validity and reliability of the study.....	75
5.2.2. Analysis bias.....	75
5.2.3. Objectivity of the research.....	75
5.2.4. Re-interviewing process.....	76
5.3. Final thoughts.....	76
5.3.1. Future research.....	78
CHAPTER 6: REFERENCES.....	80
APPENDIX 1: QUESTIONNAIRE.....	88
APPENDIX 2: INTERVIEW CONSENT.....	93
APPENDIX 3: PARTICIPANT DEMOGRAPHICS.....	94

CHAPTER 1: INTRODUCTION

In the African context childbearing is an important stage in life, and throughout the socialization process girls are taught to identify with the role of being a mother (Preston-Whyte, 1988). Therefore as part of acknowledging this important life stage, certain cultural rituals, practices and perceptions are adhered to (Brindley, 1985; Chalmers, 1990; Setiloane, 1988). In the South African context a similar perception has been observed, for example Brindley (1985) noted that within the Zulu culture mothers do not tell of their pregnancies for fear of tempting fate. A similar observation was made by Baartman, (1983) amongst Xhosa women in the Eastern Cape. The studies of Baartman (1983), Brindley, (1985) and Setiloane (1988) revealed that within the South African traditional culture childbearing is a shared family experience. The extent of social support that is provided by family members may therefore be seen as a protective factor in the experience of motherhood.

The issue of distress during the perinatal period is however not discussed in these studies. Rather, the focus is on how childbirth is a fulfilling experience for many women, although it involves changes that could be particularly stressful (Grussu, Quatraro & Nasta, 2005; Schott & Henley, 1996; Soet, Brack & Dilorio, 2003). Motherhood is influenced by an individual parent's understanding and perception of how she would like to be, and is also influenced by society's definition of this stage of life as well as by cultural beliefs and perceptions (Paris & Helson, 2002; Preston-Whyte, 1988). Culture affects the individual, and this effect occurs from the moment of birth, as parents make

culturally approved decisions about how they raise their children (Small, 1998). Therefore the way people would respond to the childbearing process is culturally and personally moulded (Preston-Whyte, 1988; Schott & Henley, 1996; Small, 1998; Varela, Vernberg, Sanchez-Sosa, Riveros, Mitchell & Mashunkashey, 2004). The effects of culture and societal perception are subject to changes that occur within the culture itself. Small (1988) argues that culture is not static and changes over time in response to new situations and pressures. The work of Baartman (1983) has revealed changes in perceptions, practices and adherence to cultural beliefs among women from urban areas, where women followed more westernized practices, while women in rural areas followed more traditional practices.

In the light of these findings, a study was conducted to investigate the experience of pregnancy, childbirth, postnatal adjustment and potential distress during this period among Xhosa speaking people of Cape Town. It is important to document how socio-cultural beliefs and perceptions are impacting on the childbearing process among women, and how much these beliefs influence perceptions. Using a grounded theory methodology, twenty qualitative interviews were conducted with Xhosa speaking participants in Cape Town. Through these interviews, hypotheses were developed to understand the influence of cultural beliefs on perceptions of pregnancy, childbirth and the postnatal period as well as potential distress during these life events.

The structure of the dissertation is as follows: Chapter Two is a review of the literature pertaining to the central aspects of the study, including important aspects of the

childbearing process, the influence of culture and the understanding of distress amongst Xhosa speaking people. Chapter Three discusses the use of grounded theory as a method of study and the process followed in analysing the data. Chapter Four provides an outline and discusses the analysed interview material in relation to the theoretical concepts discussed in the literature review. In Chapter Five concluding comments are made that draw together the central ideas emerging from this research.

University of Cape Town

CHAPTER 2: LITERATURE REVIEW

Developmentally, the childbearing process is a central stage in a person's life (Van Balen & Bos, 2004). Small (1998) argues that the childbearing process is a universal phenomenon usually conceptualised in terms of its biological nature. She also proposes that this process is a social one to which different societies attach different meanings; and further argues that the culture of a society determines how this process is perceived and how people react during this phase of life. This chapter will discuss the role of culture in relation to the childbearing process and the changes that might have occurred. The second section deals with childbearing issues in the South African context, and the last section discusses perceptions of health and illness within the Xhosa culture and how this could be related to the possible experience of perinatal distress.

2.1. Culture and the childbearing process

Small (1998) defines culture in terms of the shared and learned ideas and products of society. Further she states that culture involves the shared way of life of people, including their beliefs, technology, values and norms, all of which are transmitted through generations by learning and observation. Furthermore all humans are by nature cultural creatures living in population groups, and each group reaches a consensus about how to act in ways that promote a sense of community and belonging. Similarly Preston-Whyte (1988) stated that culture consists of both rules for doing things, including technical and scientific knowledge, as well as rules on how to behave and think.

2.1.1. The influence of culture on the childbearing process

Lefkarites (1992) notes that throughout the world the meaning of childbirth is expressed through different beliefs, customs and practices, and that these diverse cultural interpretations are part of a larger integrated system of beliefs concerning men, women, family, community, nature and religion (cited in Rice, 1999). The underlying assumption therefore is that beliefs guides the way people respond to the process of childbearing. Therefore, the experiences that people have during the childbearing process are likely to be influenced by beliefs and socio-cultural perceptions. Studies that have been conducted within South African communities show evidence of such an influence. For example Baartman (1983) found that Xhosa women believed that the information that has been passed on to them by their parents, together with the rituals to be followed during the childbearing process, needed to be adhered to without being questioned. For Baartman (1983) culture is not questionable. A similar view was also observed in the United States in support of the influence of culture on the childbearing process. A study conducted by Guerin-Weis (2000) as cited in Soet et al (2003) revealed that, in the United States, 19% of women reported having symptoms of PTSD (post traumatic stress disorder) after giving birth without perceiving it as traumatic. This was attributed to factors including the cultural reluctance of women to admit to a negative birth experience. In addition, during the postpartum period most women would follow up a negative comment about childbirth with the assurance that they were happy to have a healthy baby. It was assumed that this could be due to strong societal pressure on women to be happy with the birth of their baby, and to put the baby's health and needs before their own (Guerin-Weis, personal communication, December, 2000 cited in Soet, et al., 2003).

Looking at the abovementioned examples, one can therefore argue that, as culture changes, the lived experiences of women might change. As has already been stated, Baartman (1983) noted the change in practices among women in urban areas. Similarly, Chalmers (1990) has described the cultural changes in the childbearing process amongst African communities. Chalmers (1990) found that women in urban areas no longer adhere to traditional rituals in relation to childbearing as did women from rural areas. Similarly Brindley (1985) noted the change in childbearing practices among the Zulus in Nkandla in that most of the women she studied gave birth in hospitals, which was not the traditional practice. In order to have a clear understanding of the influence of socio-cultural perceptions and beliefs on the childbearing process, the phases of this process need to be discussed.

2.2. The childbearing process

2.2.1 *The antenatal period*

Psychological studies of pregnancy have focused on the difficulties experienced by women during this phase, such as anxiety, mood swings and antenatal depression. Shereshefsky, Plotsky and Lockman (1974) studied women's adaptation to pregnancy, and found that only variables associated with the woman's sense of self, such as her qualities of nurturance, ego strength, confidence and clarity visualizing herself as a mother, influenced pregnancy adaptation. It is however important to note that in the studies of Baartman (1983), Brindley (1985) and Setiloane (1988) there is no mention of distress during the childbearing phase. The question then is whether distress was not

mentioned because it did not exist, or in the traditional way of childbearing distress could not be identified.

2.2.2. Childbirth

There are common understandings regarding the process of childbirth and labour across different cultures (Schott & Henley, 1996). In South African cultures, there has been a similar understanding in relation to childbirth. Features such as the need for support have been identified. For example, Brindley (1985) found that amongst the Zulu people, when a woman goes in to labour, the mother-in-law and the elder women of the family gather around to give support to the labouring woman. This was needed to ensure a safe and supportive environment for the woman in labour. This practice emphasized the communal sharing of the birth experience. Setiloane (1988) found a similar practice amongst the Tswanas. Both these studies have shown how such support improves the woman's well being during the childbirth process. Wheately (1998) argues that support during pregnancy has been shown to significantly enhance women's emotional well-being.

In other studies relating to support during the childbirth process, Waldenström, Borg, Olsson, Skold and Wall (1996) found that support given by caregivers has a positive effect on women's total birth experience. Similarly Hallgren, Kihlgren and Olsson (2005) showed that support and ways of relating between expectant mothers and midwives resulted in a positive experience.

2.3. Psychological aspects of childbearing

2.3.1. Overview of childbearing distress

Ballou (1978) noted that the childbearing process is one of the life stages that places parents at greater risk of experiencing psychological distress. Several studies have been conducted to look at why this process places people in a vulnerable position. Grussu et al (2005) conducted a comparative study of mood states and parental attitudes between women with planned and unplanned pregnancies, and they found considerable psychological suffering during pregnancy in women with an unplanned pregnancy. On the other hand Hedegaard, Henriksen, Sabroe and Secher (1993) found that parental anxieties during pregnancy were also associated with distress, with experiences of antenatal care and the experience of labour being painful and complicated. It could therefore be argued that the perceptions that women carry of the perinatal phase would determine whether the experience would be regarded as distressful or not. One of the most frequently discussed forms of perinatal distress is the postpartum depression.

2.3.2. Postpartum depression

Ebert (2003) found that in the United States there is a high prevalence of postnatal distress, with 30% of women showing symptoms of post traumatic stress syndrome and 50% of women experiencing some aspects of postpartum depression. In the available literature the main focus has been on prevalence of postpartum depression, while fewer studies have looked at the lived experience of women during postpartum depression. Beck (1992) and Chan, Levy, Chung and Lee (2002) investigated the lived experiences of mothers with postnatal depression. Beck (1992) found that themes that emerged were not

assessed by the available instruments such as the Edinburgh Postnatal Depression Scale. Woollett and Parr (1997) argue that the focus on depression results in other feelings, such as the negative impact of loss of sleep and the workload of caring for a baby, being neglected. This argument is also shared by Schott and Henley (1996) who have argued that postnatal adjustment to physiological, psychological and social changes is sometimes accompanied by experiences of fluctuating emotions or the so called postnatal blues. Schott and Henley (1996) further state that many mothers experience more chronic symptoms such as tearfulness, sleep disturbances, exhaustion, anxiety and irritability, which may or may not be identified as postnatal depression.

Other studies looked at the experiences of childbearing distress with a focus on culture. Amankwaa (2000) conducted a study on the experiences of postpartum depression amongst the African American community. Amankwaa (2000) found that postpartum depression among African-American women had symbolic meaning, and such meaning was embedded in the symbolic idealization of motherhood, and the historical and cultural meanings of depression. Participants in her study described depression as something that would not be disclosed readily, because of the stigma attached to it and the negative consequences. Furthermore Amankwaa (2003) argues that African-American women share a cultural belief that depression is regarded as a sign of weakness, an inability to handle responsibilities, and this was perceived to be a threat to their position or role of being a mother.

Postpartum depression in South Africa has not been studied extensively. Chalmers (1990) suggests that within South Africa there is a possibility that its incidence is under reported or not recognized. She further noted that birthing and parenting are represented less romantically and idealistically among African women than in western societies, resulting in less difficulty in adjusting to parenthood. With regard to the prevalence of postpartum depression, Cooper, Tomlinson, Swartz, Woolgar, Murray and Molteno (1999) found a prevalence of postpartum depression in Khayelitsha, a South African peri-urban settlement of 34.7%, three times the rate in other western studies. These researchers also found that postpartum depression was significantly related to indices of social support.

Most studies on perinatal distress have been conducted in developed countries, and therefore the meanings that have been attached to perinatal distress are derived from these developed countries. It is therefore becomes important to review the perspectives and ascribed meanings found in the developed countries.

2.4. The childbearing process in developed countries

2.4.1. *Socio-cultural background*

In developed countries childbearing issues have long been central to political, religious and cultural debates. In the United Kingdom, several studies have looked at the social understanding of childbearing and how it relates to social dynamics (Declercq, 1998). In the United Kingdom maternity care has been central to the government's agenda since the 1950s. As a result in 1993 the government adopted the "Changing Childbirth" report, which aimed at transforming childbirth services. The focus was that women should be at

the centre of maternity services, which should be planned and provided around the interests of women and their babies (Declercq, 1998).

The impact of culture and socio-cultural beliefs in the United Kingdom was also observed by Schott and Henley (1996), who studied the influence of culture and religion on child bearing in the United Kingdom. They found that over the past decade there had been a dramatic change in the thinking and practice of many people concerned with the provision of maternity care, the place of birth, the process of delivery and postpartum care. Some of the changes that were explored included relying more on the care provided by hospitals and clinics, rather than on family and traditional midwives (Schott & Henley, 1996).

2.4.2. The role of social support during the childbearing process

The role of social support has consistently been found to protect women from experiencing distress during the childbearing phase. Both psychological and social support during pregnancy, childbirth and the postpartum period are important for the woman's wellbeing (Wheatley, 1998). Similarly, a woman's perception of the degree to which she feels she has satisfactory emotional and social support has been found to be related to postnatal depression (Martin, 2000). Webster, Linnane, Dibley, Hinson, Starrenburg and Roberts (2000) found that women with poor support were high consumers of health care, reported poorer health in pregnancy and postnatally, and sought formal help for such problems more often. Likewise, O'Hara (1986) found that depressed

women viewed their spouses and confidants after delivery as being deficient in the amount of support they provided.

Schumaker and Brownell (1984) defined psychological support as an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well being of the recipient (cited in Wheatley, 1998). Wheatley further distinguished between two forms of psychological support; the first being emotional support that involves reassurance, intimacy and the knowledge that one is loved and cared for; and secondly practical support, which covers all aspects of help that involves aiding an individual with a problem in a physical capacity. It has been suggested that the sources of support that have a positive impact on the individual are people closest to them, particularly their partners.

In the light of these findings, an important question is whether the childbearing process in African countries is perceived in the same way as in developed countries. The discussion to follow looks at this process with specific reference to the African continent.

2.5. Childbearing process in Africa

2.5.1. The socio-cultural background

Africa is a developing continent, with countries where large populations are resident in the rural areas, with low levels of education and income (Imogie, Agwubike & Aluko, 2002; Maimbolwa, Ahmed, Diwan & Arvidson, 2003; Telfer, Rowley & Walraven, 2002). In most African countries two forms of health care exists; the modern medical and

the traditional model (Holdstock, 1979; Hopa, Simbayi & Du Toit, 1998; Van der Kooi & Theobald, 2006). The medical model involves relying more on the westernized method of care and treatment, whilst the traditional model relies more on indigenous patterns of treatment and care. The same pattern of health care is practised with regard to the childbearing processes. The beliefs and knowledge from both practices inform the behaviour and the meaning constructed during this process (Abrahams, Jewkes & Mvo, 2002; Van der Kooi & Theobald, 2006). Evidence suggests that traditional medicine practitioners are increasingly involved in providing reproductive health care to men and women in many parts of Africa (Okonofua, 2002). This has resulted in countries such as Nigeria calling for both methods to be merged in order to promote safe practices during the childbearing process (Imogie et al., 2002). This argument comes from the realization that some of the traditional practices during childbearing are detrimental to childbearing women. However there are also those that are perceived to be beneficial (Abrahams et al., 2002; Baartman, 1983; Imogie et al., 2002). One of the components of traditional health practices is the involvement of traditional birth attendants.

2.5.2. The role of traditional birth attendants

An estimated two thirds of births in rural Nigeria take place with the help of traditional birth attendants (TBA), for instance Izugbara and Ukwai (2004) found that the attraction of TBAs had to do with their service characteristics, such as affordability, accessibility and reliability. In addition, Imogie et al. (2002) found that the tasks of TBAs also included family planning, nutritional requirements and recommendations, screening of high risk mothers, fertility/infertility treatment, and determination of ailments or

abnormalities relating to reproductive organs and reproduction. The role of TBAs also extends to the care of mothers during pregnancy, labour and the postnatal period, counselling responsibilities, and conservation of herbal plants and their derivatives. Imogie et al. (2002) further state that most TBAs are seen as members of the extended family.

2.5.3. The role of social support

Social support is a distinctive feature of the African childbearing process. Maimbolwa et al. (2003) state that a highly practised cultural custom in African countries is that a pregnant woman usually has another female member, it could be a mother, aunt or grandmother, designated to look after her from the time the pregnancy is announced until the birth of the child. Madi, Sandall, Bennett and MacLeod (1999) report that in Botswana when a woman is pregnant with her first child, traditional custom demands that her mother or other female relative look after her. Whether a woman is single or married she would have to go to her parent's home for the third trimester of pregnancy and remain there until the baby was at least one month old. Furthermore, they found that women who were supported during labour had fewer interventions because they suffered less stress, pain, anxiety, and tension as a result of the companion's presence (Madi et al. 1999).

2.5.4. The use of traditional medicine

Traditional medicine is also one of the distinctive features of the African tradition. Though most African countries are now westernized, there is still adherence to traditional

medicine. Researchers have also acknowledged the transition from indigenous traditional knowledge to the introduction of medical knowledge. However, both methods are still practised. In Gambia for example, although traditional birth attendants no longer play a major role in antenatal care, they are still accessible, culturally acceptable and economically feasible (Telfer et al., 2002). Furthermore Okonofua (2002) indicated that there is now a growing consensus that traditional medicine practitioners would be difficult to wish away in Africa, and that the best policy is to seek ways to integrate them into the formal system of health care delivery.

2.6. The childbearing process amongst Africans in South Africa

2.6.1. *Traditional childbearing practices*

Traditionally, in South Africa the childbearing process was attended at home by trusted older female members (Brindley, 1985), and children were regarded as a precious gift from the ancestors and God. Furthermore, the childbearing process was regarded as a passage of a girl to womanhood (Setiloane, 1988). The following section will discuss the traditional childbearing process with reference to the three different phases of this process.

2.6.1.1. *Pregnancy*

As has been mentioned earlier, pregnancy was regarded as a very precious period in the women's life. Several physical, emotional or spiritual symptoms were known to signal pregnancy (Brindley, 1985; Chalmers, 1990; Setilona, 1988). For example a distinct African feature in identification of pregnancy was a spiritual indication in the form of

dreams such as an elderly woman dreaming of a young woman's pregnancy within the family.

However, when it came to acknowledging pregnancy, a tradition of secrecy around pregnancy was practised (Brindley, 1985). A pregnant woman would only inform the older woman of the family, the mother in law or her own mother and then the secret would be kept amongst these women until the pregnancy was visible, after which the whole family would be informed. This was associated with fear of bewitchment and the fear that this could result in losing the baby or creating difficulties for the mother (Brindley, 1985; O'Mahony & Steinberg, 1995). In addition, Abrahams et al. (2002) found that indigenous healers and women agreed that the pregnancy period was a delicate period when women were said to be vulnerable to evil sent by others or spells. As a result a number of traditional medicines were taken during this period to protect the mother and the baby from sorcery or bewitchment. This is to ensure foetal growth and preparation for easy labour. This dual practice was also seen in the medication used during the childbearing process. Examples of such traditional medicine include the use of *Kgaba* remedies amongst the Tswanas (Van der Kooi & Theobald, 2006), the use of *umchamo wemfene* amongst the Xhosas (Abrahams et al., 2002; Baartman, 1983) and the use of *isihlambezo* among the Zulus (Brindley, 1985). All these practices were to ensure the safe passage through the childbearing phase.

2.6.1. 2. Labour

Traditionally childbirth took place at home and more than one woman helped in the delivery (Chalmers, 1990). Furthermore during this process, the well being of both the mother and the baby was important (Setiloane, 1988). As a result, the woman was surrounded by the people she knew and trusted and she was further protected by ancestral spirits and free from influences that might cause her harm (Brindley, 1985). Also present during birth was the traditional birth attendant (Baartman, 1983; Brindley, 1985). Hence a labouring woman was surrounded by support and shared the birth experience with other women in the family.

There were also other rituals that were followed during the childbearing process to make this process an important one. One such ritual was the disposal of the afterbirth by digging a hole in the hut, which was usually the grandmother's room (Brindley, 1985; Chalmers, 1990; Setiloane, 1988). This hole was also used to dispose of the umbilical cord and the placenta (Brindley, 1985; Setiloane, 1988). The burial of the umbilical cord was said to symbolise the sense of identity with the family (Brindley, 1985).

2.6.1.3. Postpartum

The postpartum period was regarded as one of the most respected and sacred periods of the childbearing process. Ceremonies were held after the birth of the baby, to thank the ancestors for a new family member, to request the ancestors to protect the baby, to name and welcome the baby in to the family, and to congratulate the childbearing woman (Brindley, 1985; Setiloane, 1988). In addition, the woman was given significant social

support (Chalmers, 1990). A ten days resting period was compulsory to allow the woman to regain her health (Baartman, 1983; Setiloane, 1988). During that period the woman was taken care of, and caring for the baby was a shared responsibility amongst other women of the family as well as neighbours (Brindley, 1985; Setiloane, 1988). One woman was specifically appointed to attend to the needs of the new mother and she was known as “*umfukamisi*” (Baartman, 1983). This woman was responsible for caring for the new mother, for instructing her about breast care and infant feeding, for caring for the newborn, and for performing traditional rites (Brindley, 1983; Chalmers, 1990). It remains unclear what happens to women currently residing in urban areas, because most of the studies that discussed such support were conducted in the rural areas.

2.6.2 Current childbearing practices among Africans in South Africa

2.6.2.1. Changes in practice

As was mentioned earlier that as culture changes, so do cultural practices. It is therefore important to acknowledge that the childbearing process will have undergone certain changes over time.

A number of authors have acknowledged that within the African community childbearing has undergone changes as a result of urbanization, with traditional practices being dropped and a move towards a more western medical notion of childbirth being followed (Baartman, 1983; Brindley, 1985; Chalmers, 1987, 1990). Baartman (1983) argues that with the influence of medical technology, education and Christianity, the traditional practices of the Xhosa are undergoing what amounts to cultural mutation. Furthermore,

the acceptance of western medicine and the emergence of the registered midwife have influenced the Xhosas to move away from traditional practices of pregnancy to more medicalised modes of attending to women during pregnancy and birth. Likewise, Chalmers (1990) argues that sources of information have changed, women now rely more on books and magazines for information about pregnancy and expectations of motherhood, and nurses are expected to provide childbirth information and parenthood preparation, as opposed to relying on elder women for guidance and information. Chalmers (1990) also argues that it is extremely difficult to maintain traditional values and practices within the constraints imposed by a technologically oriented system, as more women are delivering in hospital and clinics. Therefore, women are exchanging the traditionally offered psychological safety of the home birth environment for the medical safety of the hospital.

In support of this view, Chalmers (1990) found that signs of pregnancy reported by Pedi women reflected an acceptance of western approaches to pregnancy and this resulted in less adherence to traditional customs. However, a veil of secrecy still appears to surround the news of conception for a majority of women. What is significant is that the move to more westernized way of childbearing has also been found to expose women to psychological vulnerability. Chalmers (1990) has also argued that moving towards a more medicalised model promises better physical care of the mother and the baby, but less mental, emotional and spiritual preparation for birth and parenthood.

2.6.2.2. The use of traditional medicine

Abrahams et al. (2002) found that two thirds of the Xhosa speaking women followed indigenous healing practices for themselves and their babies, or reported having done so with previous pregnancies. Furthermore, women also expressed the need to consult biomedical care (for reasons such as to know how the baby was positioned). Van der Kooi and Theobald (2006) observed a similar pattern among Tswana women, who perceived pregnancy and labour as a process that needed follow up and control from western oriented clinics, as well as protection from harm or evil spirits by the use of traditional medicine.

This dual use of medication led to many authors promoting the need to combine the two form of practice. Abrahams et al. (2002) indicated that there was a need to develop an understanding and recognition of the value of indigenous knowledge. They further noted that a way to harness and integrate the beneficial aspects and needs of African and Western views of obstetrical care must be found. This would help in developing a cultural understanding of a need-fulfilling practice for the African patient in labour in the Western childbirth setting (Fouche, Heyns, Fourie, Schoon & Bam, 1998).

Having discussed the childbearing process and the changes that have transpired within this process, it remains important to also look at an understanding of health and illness from a South African perspective.

2.7. Perceptions of health and illness

2.7.1. The definition of health by the World Health Organisation (WHO)

Before discussing the issues of health and illness in the South African context, it is important first to consider the international views on health and illness. The WHO defines health as complete physical, mental and social well-being, and not merely the absence of disease or infirmity (Smit, Bekisnika, Ramkinsoon, Kunene and Penn-Kekana, 2004). As cultural representations of the human body, time, life, death and disease vary, so do people's approaches to action, prevention and treatment vary. Procreation, childbirth, weaning, sexuality, death, disease and suffering are not just private experiences, but all have an intrinsic social dimension. Similarly, the health conditions in which they take place are often determined as much by cultural practices as by biological and environmental factors (Nakajima & Mayor, 1996). Thus the perception of illness and health is determined by the dominant ideology that guides ways of being and practice under such circumstances (Davis-Floyd & Sargent, 1997; Sakalys, 2000). This understanding confirms the previous discussions that the experiences of a person would depend largely on what perceptions and beliefs that society holds towards such experiences.

2.7.2. The South African health context

The Republic of South Africa is a diverse country. The country is divided into nine provinces with eleven official languages and has a history of racial segregation. These racial groups were divided into four, viz, Whites, Indians, Coloureds and Blacks (Chalmers, 1990). The Black communities are further divided according to ethnic groups including the Sotho and the Tswana, Venda and Pedi found in the North Western parts of

the country; the Zulu and Ndebele found in the Western part of the country; and the Xhosa located in the Eastern and Western part of the country (Warmelo, 1974). The health system was also fragmented and services were provided according to the above-mentioned segregations; and were further characterized by disorganized services, low morale in the health sector, low levels of literacy especially among rural women, and inadequate infrastructure (Fonn, Xaba, Tint, Conco & Varkey, 1998).

In 1994 the first democratic government was elected in South Africa. It was after the election that the Minister of Health introduced the White Paper for the transformation of the health system in South Africa (Fonn et al., 1998). The aim of the White Paper was to restructure the health system from a largely curative based and fragmented system to a more community orientated one, based on primary health care principles. The emphasis was on preventative, promotive and curative services. Women's health and reproductive health were also a focus of this document. The White Paper was adopted in 1996 and some of the stipulated principles concerning women's health were that maternal, child and women's health services should be accessible to mothers, children, adolescents and women of all ages; and the focus was to be on the rural and urban poor and farm workers. In line with this stipulation the Department of Health offered free antenatal care to mothers, free postnatal care for children below the age of five, and services were spread to reach people in the rural areas. By doing this the department showed its commitment to improving the quality of services offered, in order to enable the health sector to make its contribution to the reduction of infant, child and maternal morbidity and mortality (Smit et al., 2004).

This saw a change in the utilization of antenatal and postnatal care in South Africa. In 1998 over 94% of pregnant women received antenatal care services and 84% of births were supervised by a skilled health provider (Smit et al., 2004).

2.7.3. Perceptions of health and illness within the Xhosa community

2.7.3.1. Nature of illness

Culture plays a role in determining how people understand their world (Brindley, 1985; De Villiers, 1985; Preston-Whyte, 1988; Rice, 1999). A study conducted by De Villiers (1985) in the Eastern Cape revealed that in the Xhosa tradition illness is regarded as a type of misfortune. Consequently ideas about causes are closely associated with ideas about misfortune in general. Murdock (1980) as cited in De Villiers (1985) provides three categories of perceptions of illness within the Xhosa community: animistic causation, which is manifested as the aggressive or punitive action of an affronted supernatural being; mystical causation, which is attributed to taboo; and magical causation, which is associated with the deliberate invisible action of malevolent beings and creatures.

On the other hand, Cheetham and Griffiths (1982) state that the overall conception of illness within the Nguni tradition is that people provide explanations for illness in terms of biological (related to beliefs regarding malfunctioning of the organism), social (non-observance of restrictions placed upon the individual by the society), religious (pervading influence of the ancestors), and magical (principally related to sorcery) factors. Furthermore the Nguni people regard a human organism as a whole which is integrated within the total ecology of the environment and with the interrelated spiritual, magical

and mystical forces surrounding him/her. Therefore the conceptual model of health is couched in terms of a balance between a healthy body and a healthy situation hence “good health means the harmonious working and co-ordination of their universe” (Cheetham & Griffiths, 1982, p.954).

This perception of illness would then guide the approach to help seeking behaviour. In most cases traditional healers are approached when illness arises as they are believed to have knowledge about these causes (Cheetham & Griffiths, 1982; De Villiers, 1985).

2.7.3.2. Perceptions of Mental Illness

Cheetham and Griffiths (1982) have argued that mental illness is also understood in the same way as physical illness amongst the Nguni people. However, a distinct feature is that it is mainly circumstances that constitute a threat to social cohesion and balance that are regarded as “madness”. Cheetham and Griffiths (1982) also state that there is an extensive differentiation in diagnosis that occurs, and they attribute this to whether the community has the linguistic or the professional resources for understanding mental illness. On the other hand Swartz (1991) has argued that in African communities, stress is perceived as referring to agency external to the person. In support of this view, Robertson and Kottler (1993) conducted a study exploring indigenous expressions of psychological distress in children and adolescents in Gugulethu, Cape Town. They outlined a description of symptoms and proposed aetiology of various culture specific syndromes. Some comparisons were made with western psychiatric disorders, such as *ukuphaphazela* which was seen to describe panic disorder and *amafufunyane* which may resemble

hysterical psychosis. However there were no specific categories of mental illness, for example Robertson and Kottler (1993) found that the term *ukuphambana* is used non-specifically and apparently pejoratively to denote psychotic behaviour.

Ensink and Robertson (1994, cited in Kirk, 1996) found that patients and their families often use a combination of psychological and indigenous explanations for their experiences. They further noted how certain explanations drawing on indigenous and other sources of knowledge are combined to construct meanings, and these do not fall neatly within the different categories of illness, either indigenous or psychiatric. Moreover, Cheetham and Cheetham (1976) studied the concepts of mental illness within the Xhosa community and they provided the following aetiology of mental illness:

- Failure to propitiate the ancestors with the necessary sacrifices or rituals
- Non-observance of taboos and the consequent ancestral displeasure
- Bewitchment in which the mind has been removed through a sorcerer who has obtained a potion or evil influence from an “ixhwele”
- Object intrusion in which removal of the mind has occurred through the actions of the familiars such as ‘tikoloshe’ making incisions under hair line
- Intrusion of evil spirit sent by sorcerers
- Bad blood and foam reaching the brain
- Excessive worry over matters which ‘have been kept to oneself.

2.8. The aims of the study

The purpose of this study was to make a contribution to the understanding of perceptions and socio-cultural beliefs on the childbearing process and possible related distress. Furthermore the study seeks to understand the role of socio-cultural beliefs in this process. In the light of the findings revealed in the literature discussed in the previous chapter, the current study therefore aims to explore the following:

1. To develop an understanding of the childbearing distress in an urbanised Xhosa population.
2. To develop an understanding on whether support provided during the childbearing process is perceived to be a contributing factor that protects Xhosa women from experiencing perinatal distress.
3. To understand if Xhosa speaking people in Cape Town perceive psychological distress during the perinatal process to be related to circumstances in the person's environment and distress is seen as a response to these unfortunate circumstances.
4. To gain an understanding of whether mental distress within the Xhosa community is attributed to sources beyond the individual's control, such as sorcery or an unsupportive environment.

CHAPTER 3: METHODOLOGY

This chapter will provide a motivation for conducting a qualitative research study and describe the research method utilised.

3.1. Grounded theory

Chenitz and Swanson (1986) state that like most other qualitative research, grounded theory makes its greatest contribution in areas in which little research has been done. Grounded theory research was considered a suitable method for the current study. The purpose of grounded theory is to study social phenomena from the perspective of symbolic interactionism (Eaves, 2001). Therefore grounded theory makes an attempt to gain meaning and understanding of people's experiences from their actual social and psychological context (Chenitz & Swanson, 1986).

Grounded theory is a highly systemic research approach for the collection and analysis of qualitative data for the purpose of generating explanatory theory that furthers the understanding of social and psychological phenomena (Chenitz & Swanson, 1986). This method of study allows participants an opportunity to voice an understanding of their own lived reality and provides valuable insider knowledge. Grounded theory therefore allows the theory to emerge from the data, and thereby resemble reality, offer insight, and enhance understanding of phenomena being researched (Strauss & Corbin, 1990).

3.1.1. Data collection, analysis and sampling using Grounded Theory

In the grounded theory approach the process of collecting data, analysis and the nature of sampling occurs simultaneously (Glaser & Strauss, 1967). In grounded theory study the

sample is not selected from the population based on certain variables prior to the study. Data collection is guided by a sampling strategy called theoretical sampling. Glaser and Strauss (1967) proposed that theoretical sampling is the process whereby the analyst jointly collects, codes and analyses data, and decides what data to collect next and where to find them. Theoretical sampling is based on the need to collect data to examine categories and their relationships and to assure that representatives in the category exist (Chenitz & Swanson, 1986). Strauss and Corbin (1990) argued that theoretical sampling as an analytic tool in grounded theory proposes that, as new cases emerge and the project continues, the active analysis of the new case should continue.

Semi-structured qualitative interviews were chosen as the most appropriate research instrument. The semi-structured interview is an open and flexible research tool which allows for the exploration of complex issues and gives participants an opportunity to express themselves freely, rather than limiting responses to a standard format (Banister, Burman, Parker, Taylor & Tindall, 1994). Participants can introduce new material and perspectives which may not have been anticipated by the researcher, leading to richer research material, thus the interview can be tailored to the particular participant and the position communicated, with the interview schedule providing a loose framework for the researcher (Banister et al., 1994).

The analysis process using grounded theory begins early in the research process. From the first data that is collected constant comparison of the data is made throughout the research process (Chamarz, 2000). The first step in the analysis process begins with

coding the data that is obtained from the interviews. Strauss and Corbin (1990) stated that coding represents the operations by which data are broken down, conceptualised, and put back together in new ways. The words of the subjects themselves are used and the researcher reads through all transcribed data, and codes emerge from the data (Chenitz & Swanson, 1986), so that the researcher develops codes as the data is being studied (Chamarz, 2000). Codes are then compared with each other for similarities and differences; similar codes are clustered and given an initial label and a category is formed (Glaser & Strauss, 1967). Once the researcher has identified particular phenomena in the data, the process of grouping such data into certain concepts follows. The process of grouping the concepts that seem to pertain to the same phenomena is called “categorizing” (Chamarz, 2000). Strauss and Corbin (1990) define categories as abstractions of phenomena observed in the data, and they form the major unit of analysis in the grounded theory method. Data collection continues until categories become saturated, that is, no new data or no additions are added to the category (Chenitz & Swanson, 1986).

There are no set rules to determine what is sufficient. The analyst can, however, feel confident that the field has been thoroughly explored when no further categories emerge from the data, the categories are dense and well developed, the same patterns are seen repeatedly, and there is no variation (Amankwaa, 2000).

3.2. Participants

The interviews were conducted with 20 participants who were drawn from communities around Cape Town using the convenience sampling method. A total of 20 participants

were interviewed. The sample consisted of four fathers, four postpartum mothers, four participants with the experience of assisting mothers during childbearing process(two of the birth attendants were professional nurses with midwife experience and two were traditional birth attendants), three grandmothers and five pregnant women. Sample size was considered to be sufficient in order to elicit major, repetitive themes (Chenitz & Swanson, 1986). All participants were Xhosa speaking and were all originally from the Eastern Cape, with most still regarding it as their home of origin. Most of the participants still had their extended families in the Eastern Cape and they visited home annually. Participants ranged from the age of 20 to 60. Their educational level ranged from standard 2 to postgraduate qualifications (see Appendix 03 for participants' demographics).

3.3. The Interview Structure

Each interview lasted for about an hour to an hour and half. The first part of the questionnaire consisted of demographic information. The second part focused on how pregnancy is understood and how it is communicated and how it is socially constructed. These questions explored the information about pregnancy and related emotions. Socio cultural influences were also explored, looking at the role of spirituality or supernatural belief in the understanding of pregnancy.

The next set of questions related to the childbirth process and the role of support. The aim was to explore what kind of support was given, whether it was seen as necessary or and important or not. The role of significant others and partners during the childbirth process

was explored. These questions also aimed at exploring any changes in cultural patterns during the cultural transition, e.g. the place of birth, the role of partner during the childbirth process.

The next set of questions related to the postpartum period: the aim was to explore the understanding of changes experienced during this period and what emotional connections were made. What set of beliefs and cultural practices were associated with this period. How did such beliefs and practices translate in to childcare?

The interview was administered by the researcher personally and the questions asked were guided by the participant's response (see Appendix 01 for the interview schedule).

3.4. Setting

The research was conducted in two areas of Cape Town. Three of the participants were drawn from the area of closed community in Monte Vista and all other participants were drawn from Khayelitsha. Both areas of study were chosen because of availability of respondents and also because of the researcher's familiarity with these environments.

Monte Vista is an urban area situated alongside the N1. All the respondents from this area were employees of correctional services and had at least a postgraduate learning experience. The population in the area is mixed with Whites, Indians, Coloureds and Africans residents. The Xhosa speaking African residents mostly originally from the Eastern Cape and came to Cape Town for studying and work. The ages of respondents in

this area ranged from 29 to 35. The respondents resided in the rental formal residents with a population estimated to ± 400 .

Khayelitsha is situated within the Western Cape Province, located at the South Western tip of South Africa, located in the Cape metropolitan region. It is situated 25 km from Cape Town central business district along the N2 national road. It is a semi informal township where there is an almost proportionally equal formal dwelling and informal settlements with a population estimated to $\pm 600,000$ (Space Time Research, 2006).

Respondents from this area ranged from qualified professional to unemployed respondents. Educational level ranged from standard 1 to postgraduate education. Though Khayelitsha is a peri-urban area there is still however some practice of the traditional Xhosa rituals such as:

- Traditional healing and associated cultivation of medical plants.
- Burial rites, e.g. ritual of washing of the hands, sacrificial slaughtering, etc.
- Traditional medicinal cleansing practiced by men and women, and
- Initiation ceremonies such as initiation of Izangoma and Abakhwetha (young men).

Access to the community of Monte Vista was obtained through speaking to the Area Manager of getting an opportunity of interviewing participants after working hours.

Access to the community of Khayelitsha was obtained through a community worker at the Parents centre situated at the Town II community health centre in Khayelitsha. This

community centre consists of the parents centre, the children's clinic and the TB clinic and the HIV/AIDS counselling centre. The main function of the parents centre is to offer emotional and educational support to parents who are having difficulties with their role as parents. After building a trusting relationship with this community worker and having explained the purpose of the study and the intended sample. She then introduced me to the sister in charge at the children's clinic. At the clinic babies are brought for their immunization, monitoring of growth and when they are sick during the postpartum period. The clinic sees to children from age of one month to seven years.

The sister informed me that in this clinic I would be able to see postpartum mother and they do have few grandmothers who sometime come bringing their grand children to the clinic, if I need access to pregnant mothers I would have to go to The MOU unit in a near hospital. She then gave me contact details for the MOU clinic.

The same procedure was followed in gaining access at the MOU clinic, where permission was obtained from the sister in charge and the research proposal to explain the purpose of the study was provided.

The community worker also assisted me in introducing me to some community members that we perceived suitable for the study. This assisted me since it was easy for people to trust me and allow me to interview them. Some of the interviews were conducted in the respondents own home, which are also in the vicinity of the clinic.

3.5. Ethical permission

Permission to conduct this study was obtained from the University of Cape Town faculty of humanities research ethics committee. Access to the subjects was obtained by approaching the participants personally with the assistance of the community worker. Written consent to be included in the study was obtained from the participants. The aim of the study was explained and ethical considerations regarding confidentiality were explained to the participants. Participants were interviewed in their homes as well as in the community clinic. Consent to conduct the interview was obtained from the respondents a day before the actual interview.

The purpose of the study was explained to the community worker and the sister in charge at the children's clinic. In this clinic babies are brought for their immunization, monitoring of growth and when they are sick during the postpartum period. The clinic sees children from the age of one month to seven years. Verbal permission was obtained to conduct the study. Pregnant mothers were recruited from the local maternal obstetric unit (MOU). Verbal permission was obtained. Office space was provided in order to conduct the interviews.

3.6. The interview

Selecting participants was an informal process. Interviews were conducted in Xhosa. The interviews were tape recorded. The interviews varied in length, lasting from an hour to an hour and half. The interviews were transcribed and translated into English. Translations were checked by a colleague whose first language is Xhosa and is a health professional.

3.7. The analysis process

Using grounded theory, the analysis process consisted of a number of steps.

3.7.1. Developing codes and categories

After completing the first five interviews, the data was transcribed and translated into English. The analysis began by reading through the transcribed data from each interview category. Each interview transcript was divided into two columns, the first column consisted of the respondents' actual responses. The respondent's responses were read line by line. Codes were attached to each line. The second column of the interview transcript consisted of the attached codes. Codes reflected central thought patterns in the interviews. Following the grounded theory method the interviews were coded with no specific set of codes in mind (Amankwaa, 2000). A total of 80 codes were generated.

3.7.2. Developing higher order categories

The process then involved reading each specific code and observing similarities between the codes. The codes that emerged with similar meaning were combined into one. The merging of different codes led to the development of higher order categories. A category consisted of a number of codes that carried similar meaning. The sampling of participants for further interviews was identified relating to the categories that needed to be explored further in order to identify if such meaning existed across different categories. The process of coding and categorizing was repeated by finding comparisons and differences

between the categories for every new transcript. This was repeatedly done until there were no new codes and categories that emerged (Strauss & Corbin, 1990).

After the desired number of participants was interviewed and data analysed, a total number of 35 categories emerged. A process was followed where comparisons and differences were again observed between the categories. Finally a total number of 18 categories emerged.

3.7.3. Development of themes

Categories were then carefully studied for similar meanings, and were then combined into themes. For example category one and two spoke about the task that a woman carries in the childbearing process. The theme of childbearing as a sacred life task emerged from this understanding. Chamarz (2000) describes a theme as a statement of meaning that runs through all or most of the pertinent data, or one in the minority that carries heavy emotional or factual impact. Themes were further compared and contrasted to find common meaning.

3.7.4. Development of hypotheses

The meaning that emerged from the themes was consolidated to find a common perception and understanding. This therefore led to the development of hypotheses. Three hypotheses emerged from the data that consolidated the main themes of the study.

CHAPTER 4: RESULTS AND DISCUSSION

This chapter will provide the findings of the current study. Only the final 18 categories are presented. Following the grounded theory analysis process the categories were consolidated and organised into themes. A total number of nine themes are presented. The hypotheses that emerged from the study will also be discussed. Table 1 outlines the categories. Each category will be presented with examples from the transcribed data that support the category.

Table 1

	CATEGORY	EXAMPLES
1.	Childbearing defines womanhood	<i>"I think if your wife does not get children, it impacts on her dignity as a woman and especially wife"</i> (Participant 06) <i>"...it is important for a woman to have a baby, in this case married or unmarried but in terms of age you must be at the right age whereas you must know that you can be able to give birth so if you are a woman and you are able to have kids it is a precious gift you must give thanks to God"</i> (Participant 20).
2.	Protecting the foetus	<i>"When a woman is pregnant she must always take care of herself. She must protect her life and the baby's life. Because if she wanders around, especially in today's youth, they drink, go out to night clubs, that is not allowed with pregnant woman. She needs to be always at home. She must always be clean, love herself because anything could happen to a pregnant woman when you are pregnant you must be careful on what you do, you must stay away from the use of alcohol and drugs in order to protect your baby"</i> (Participant

		<p>04).</p> <p><i>"firstly you don't have to stand a lot and they say you must not walk a lot, because you might catch evil things and then the baby will have a problem"</i></p> <p>(Participant 10).</p>
3.	A sense of belonging	<p><i>"I don't know whether it could be possible to get the placenta from the hospital, anyway even before it was disposed, only if they do it the right way, than I'll be ok, it can be left at hospital. But the part of the cord that remain with the child, in most cases in hospital they clip it with a peg, so when that drops after healing they need to do the old ritual of burying it in a safe place in the house. Then at least people will be able to say here I belong"</i></p> <p>(Participant 01).</p> <p><i>"The umbilical cord especially was buried either at the fireplace or in the kraal so that when you speak you can identify your place of birth, where you belong. Even now I always say my cord is at Engcobo and that is where I belong. Even now the way I'm missing home I can feel I would not be right if I don't go there. I don't know whether it is that connection that I have with my home that a piece of me is there, so it will always connect me with home"</i></p> <p>(Participant 04).</p>
4.	Ancestor as a source of health and protection	<p><i>"The reason is because of ancestors. If you have a baby and had buried the umbilical cord at home, every time the ancestors come to visit they see that there is a new member in the family, so then they would know that they have to guide and protect the new members also, so when you do the rituals they would also go well"</i>(Participant 16).</p>

		<p><i>"Yes, because if it is not there your ancestor don't know about it. You see even when we take it home, we don't just go and put it there, we will slaughter a sheep and report my grandchild to our ancestors so that when she grows up, wherever she goes they will be with her and would protect her. So if that is not done there would really be difficulties" (Participant 17).</i></p>
5.	<p>Childbearing as a self identity changing experience</p>	<p><i>"To be honest, there is a huge change in my life ... My thinking and perception of life is different. Before this I was not even thinking of getting married but things have changed" (Participant 01).</i></p> <p><i>" ...Yes, I'm normal thin and slender having a nice body. I like dressing up beautifully with clothing that shows that fits me well and wearing high heel shoes. So now I have to wear flat shoes always and wearing big clothes that are wide open, I can't even wear my pants. I don't like the way I look, it is not my style and I don't feel good about myself..... I planned to get pregnant but now I cannot even go to work, because when I'm at work I have to be on my feet most of the time. Now it is festive season if I was working I could have had my own money but now I have to depend on my husband with everything. Though he is happy to do that but I'm the kind of person who likes her independence. I don't like to be totally dependent on the other person but because he is the one working I have to depend on him" (Participant 02).</i></p>
6.	<p>Planning and readiness</p>	<p><i>"Like your girlfriend tells you, she is pregnant and you were not expecting that. It is frustrating and results in breaking of a relationship. You have to discuss in advance having a baby so that when it happens you'll be ready"</i></p>

		<p><i>"planning is important having a baby is very expensive" (Participant 01).</i></p> <p><i>"I nearly had a stroke after I came to Cape Town, I got pregnant unplanned ... I was emotionally disturbed and that affected my baby's health ... that is why I emphasize planning for the baby" (Participant 03).</i></p>
7.	Negotiating cultural transition	<p><i>"I would have preferred that since our grandparents believed in way that they believed is right. If they could also be given a chance to be there and be allowed to do their rituals. In our days, they do the hospital way and our traditional way ends up being ignored" (Participant 01).</i></p> <p><i>" These are traditional things, it s knowledge we got from our parents, who also got it from their parents, so it is coming back from our ancestors" (Participant 17).</i></p>
8.	Childbearing as a source of women's power	<p><i>"We as Xhosa people, you cannot be present during the time of childbirth that is for white people to do. As a Xhosa man you can only take your wife to hospital and when you are there you can get the hospital details so that you will find out what is happening but you cannot be present. I've got three children but I don't know what happens during the process of childbirth. I have never been present" (Participant 03).</i></p> <p><i>"I don't like men coming during labour because we as women do not go to the mountain when they go for circumcision. So you see giving birth is a private thing for women. Men can know about it but they must not be there. That is a Xhosa tradition" (Participant 17).</i></p> <p><i>"No, I don't think men should be present during labour. This is a private thing</i></p>

		<i>for women, same as men circumcision women are not allowed to be even nearer, I think the same principle should apply to childbirth” (Participant 05).</i>
09.	Connection between physical and psychological well-being	<p><i>“....when a postnatal woman is emotionally disturbed it takes time for the womb to heal it has to do with the connection between the blood vein to the brain and the womb, that is the reason why a woman could be mentally disturbed if not taken care of her emotional needs after giving birth” (Participant 19).</i></p> <p><i>“....especially if you are breastfeeding, they say you must not be emotionally unwell because your milk turns weak and then would make the baby sick” (Participant 10).</i></p>
10.	Support as a family responsibility	<p><i>“They cook special meals for you such as mealiepap, since you are breastfeeding you have to have breakfast, lunch and supper and all of that will be done for you. I forgot to mention it earlier that this time is also used especially if you are a first time mother to teach about how you take care of yourself and the baby” (Participant 03).</i></p> <p><i>“ I was never emotionally unwell during my pregnancy. I got married very young and my in laws loved me very much, so far all my pregnancies I had everything I needed and there were always people around to give me support”. (Participant 18).</i></p>
11.	Culture of not questioning authority	<p><i>“When we were still young whatever our parents told us we valued, we did exactly what they told us, we never questioned them, we respected their views” (Participant 18).</i></p> <p><i>“You know, in our culture you never talked back to the elders, so if you are</i></p>

		<i>being told of the information you just take it as it is” (Participant 19).</i>
12.	Holding information as a source of protection	<p><i>“ You must not tell of your pregnancy to other people, because if you do it will give them a chance to cast a spell” (Participant 13).</i></p> <p><i>“Most of the times other relatives and family will be informed of your pregnancy when it already showing off. This was done also to avoid having many people knowing with the fear that if too many people know whilst it is still in early days, in our days you could not trust other people because you would know who is happy for you or who is not. The belief was that people who are not happy with the pregnancy, may cast the bad spell and you can end up loosing the baby” (Participant 03).</i></p>
13.	A culture of silence	<p><i>“I should think it also comes from the way we have been brought up and taught that one should not openly discuss his difficulties with her partner. You know when you get married your family advise not to discuss your problems with your husband with other people. You will find that most people suppress their feelings, this also happens with young mothers, no matter how you try to talk to them about what you observe you will never get co-operation from them, the only response you will get is that everything is right” (Participant 08).</i></p>

14.	Authoritative knowledge	<p><i>“Eish, we totally do not like the use of those things. We discourage our patients from taking such medication. Especially <u>umchamo wemfene</u> because it is orally taken, then if you have drunk that it becomes a problem, the women experience on-going labour pains because this thing initiates a pain that was not there. The women will have these on going pains, then again when the water breaks; you find that her water becomes yellow or green, as if the baby is tired whilst the baby is fine. In most cases you find that the baby will end up being distressed, and for unfortunate situations the baby dies. but people do not listen. There are those who would listen to what we told them and will stop the use of these mixtures. even if we discourage the use but when they say they have to use these ointments to protect themselves to whatever they believe poses a threat or danger to them and their babies what can one do, we only request them no to use these ointments when they are coming to the clinic because we will have to touch their bodies during examinations however we totally discourage anything that is taken orally..... for all of us I think we feel the same because our patients do not listen to what we inform them. So it causes frustration to us, because it feels like they do not hear and understand what we say” (Participant 15).</i></p> <p><i>“....we strongly encourage people not to use medication that is not prescribed by the doctor because we know that the doctor will prescribe something that is good for the baby” (Participant 08).</i></p>
15.	Christianity altered tradition	<p><i>“Perhaps they could have from my partners side but my family are religious people and we do not do any cultural rituals” (Participant 14).</i></p>

		<p><i>"I don't think it is right to take all kind of medicine (Xhosa mixtures) unless you are experiencing a certain problem then the doctor will prescribe something.....not that I have something I against them, thought sometime I don't trust because I don't know what they are made of, but as a Christian I believe more in prayer"(Participant 04).</i></p>
16.	Childbearing as a shared responsibility	<p><i>"I refer mainly to being emotionally supported, that your partner should show that they care for you, be there when you need them because you can have all the money in the world but if you do not have someone who is there for you, someone showing love and appreciation, then you will not be right. I believe you both have to work together taking care and raising the baby, you did not make the baby by yourself. If he would not be there it is no use, it is even better when he has denied paternity because at least you know from the beginning that you are alone for the baby" (Participant 13).</i></p> <p><i>"....we both made the baby, so we must share the responsibility. If the my wife is with me even if I'm going to work I have to wake up early to prepare things that she would need for the day and had to make sure that in my absence I have asked someone like a relative to assist"(Participant 17).</i></p>
17.	Adhering to tradition facilitates support	<p><i>"He is around I've never seen him, he has not even paid the damages, not supporting the baby, I've not heard from him and his family. So this baby is mine, I don't even want my daughter to take the baby to show him, I want nothing from him, this is my child" (Participant 17).</i></p> <p><i>"I did not have that opportunity because every time I make a suggestion, her mother reminds me that I have not paid the damages so I don't have the right</i></p>

		<i>to an opinion about what happens with the baby, they just tell me that I have to pay what I'm supposed to pay then I can ask those questions for now I don't even have a right to ask that"</i> (Participant 16).
18.	Distress as a result of an unsupportive environment	<p><i>"It does happen these days but in our days it was not like that. In our days there was people around to give me support ... you could not even feeling the baby's strain because my family took turns in caring for the baby so I was never overwhelmed by the whole process of the baby... these days it is because once these children get babies, their partners disappear and do not give any support, so that is what frustrates them. It is not right to have a baby with no father and no one to provide support or the father denied paternity"</i> (Participant 18).</p> <p><i>"I think it is the same after giving birth, she can be easily frustrated, but that is how I think I don't know whether it is right or wrong. Another thing these days we do not have extended families, people who would help with the baby"</i> (Participant 19).</p>

4.1. Themes.

The following themes emerged from the analysed data.

4.1.1. Childbearing as a sacred life task

The childbearing process was defined by participants as a life task that every woman should go through, a process that symbolized growth. Participants supported this by stating:

"I think if your wife does not get children, it impacts on her dignity as a woman and especially wife" (Participant 06).

“I got pregnant inside wedlock, and when you are married you need to have children”
(Participant 13).

Preston-Whyte (1988) examined the issues of fertility and cultural influences, and found that within the African traditional culture a wife must have children and if she could not have children then she was neither a wife nor a woman. Similarly Setiloane (1988) stated that the marriage of a woman was not complete until she gave birth, while Brindley (1985) found that within the Zulu culture it was most important for a woman to bear children, and there was pride in having children. These data suggest that in this sample childbearing defined womanhood.

A woman had to sacrifice a lot regarding things she could or could not do in order to ensure that it was a success. All the respondents stated that a pregnant woman should refrain from poking her head in and out of the door to avoid the risk of the baby or afterbirth emerging and retracting during delivery. Another belief involved avoiding walking at night because of evil spirits that one may walk over. One participant supported this by saying:

“A pregnant woman must not walk at night. This is our belief. If she goes at night she could catch evil spirits and that could result in her losing the baby...she must not be always sleeping, because it is believed that if she does the baby will also sleep a lot”(Participant 01).

Within the traditional culture a number of activities are performed to make sure that the foetus is kept safe. Chalmers (1990) noted that there are rituals and activities that a woman needs to perform to make sure that everything goes well during this time, including notification of pregnancy. Firstly announcing and verification of pregnancy is done during the later months to avoid the practice of sorcery that could lead to miscarriage and death of the foetus or the mother. Similarly, Brindley (1985) found that mothers would verify pregnancy around the fourth and fifth months because they feared that others might try to practise sorcery and cause them to miscarry or die in childbirth. Other traditional practices involve the sitting position of a pregnant woman, where a woman is advised to sit in an upright position so that the embryo will be positioned correctly. Respondents in the current study revealed that they followed these practices, because they were uncertain of the consequences of not following them.

Participants reported that the sacred nature of the childbearing process was also observed during the postpartum period and was signalled by the careful disposing of the umbilical cord. The meaning attached to the relationship between the parent and the child and how the umbilical cord was dealt with reflects identity:

“But with the umbilical cord, when it has healed and it drops from the baby, older people must take it and bury it. So that when the person is older he/she will say I swear I was born in that place where my umbilical cord is, that is our culture” (Participant 09).

However, participants raised the concern that this practice was no longer followed and that this may have implications for future generations identity.

Brindley (1985) and Setiloane (1988) also confirmed this sacred notion of burying the umbilical cord and the placenta. Both authors mentioned how careful consideration is taken to dispose of them and to protect against their being used for sorcery. A connection is made between the mother and the baby. As Brindley (1985) stated, the naval cord is regarded as being part of the flesh of the baby, just as the placenta is part of the woman. Setiloane (1988) mentioned the ceremony that is performed after the baby's umbilical cord has fallen to welcome the gift (the baby) from the ancestors.

4.1.1.1. Traditional medicine

Another important aspect is the use of traditional medicine during pregnancy to strengthen and protect the foetus. Mixtures such as “isihlambezo” and “umchamo wemfene” were reported to be used by respondents. Studies by Brindley (1985), Abrahams et al (2002) and Van der Kooi and Theobald (2006) found that women still use traditional remedies to protect themselves from harm and evil, to strengthen the foetus, to stimulate prolonged labour and to induce labour when overdue. One participant confirmed this by saying “*You have to drink traditional Xhosa herbs to assist in preventing complications during pregnancy or the risk of miscarriage*” (Participant 05).

Another theme was the umbilical cord as a source of informing ancestors about the new family member and ensuring protection: “*....if it is not there (umbilical cord) there would really be difficulties.... it does create bad luck, because if it is not there, your ancestor would not know about you then you will not be connected with them*” (Participant 17).

“The reason is because of ancestors. If you have a baby and had buried the umbilical cord at home, every time the ancestors come to visit they see that there is a new member in the family, so then they would know that they have to guide and protect the new members also, so when you do the rituals they would also go well” (Participant 16).

4.1.2. Childbearing as a process of transformation

The responsibility that comes with this change was described as overwhelming and could alter one’s self image and life expectation: *“To be honest, there is a huge change in my life. Because this will be my second baby with her, I gave it a lot of thought and I came to a decision that since I’ve been in a relationship with her for quite some time now, I now have decided to marry her. So I could say that is how my life has changed. My thinking and perception of life is different. Before this I was not even thinking of getting married but things have changed”* (Participant 01).

“It’s like life is different when you have a baby. Like if you don’t have a child and you have planned to go to town and to be leaving at 8, you can do that but it never possible to do that if there is a baby around. Because even if you can wake up as early as possible baby’s needs always comes first, so the baby will perhaps be crying so you’ll have to stop everything and concentrate on the baby” (Participant 11).

This aspect of change reflects a new identity for parents. Nicolson (1998) has pointed to the dual role as a woman and with responsibilities and relationships attached to it. Women evaluate their personal worth through their relationship with their children and the ability to give birth. Nicolson (1998) further stated that women who become mothers

may lose their autonomy, sense of identity, work, time and friends, relationship pattern, sexuality, sense of their own bodies and health and comfort.

4.1.3. Planning and readiness

All participants expressed the need to plan and be ready for the process of childbearing, as a way of protecting one from emotional pressure that could lead to distress:

“Planning is important having a baby is very expensive”(Participant 20).

“I nearly had a stroke after I came to Cape Town, I got pregnant unplanned I was emotionally disturbed and that affected my babies health...that is why I emphasize planning for the baby” (Participant 03).

The issue of being ready for the parenting task has also been discussed by Grussu et al. (2005), who found a considerable amount of suffering during pregnancy in women with unplanned pregnancies. They found that one, six, nine and 12 months after birth, women with unplanned pregnancies demonstrated greater mood disturbances than women with planned pregnancies.

Another argument regarding planning and readiness that came out in the current study had to do with teenage pregnancy. Most of the respondents acknowledged the challenges of teenage pregnancies and the emotional immaturity of teenagers having children. One of the young mothers in this study expressed this feeling:

“I thought that I got this child when I was still a scholar. My mother was not impressed by what I did. I lost a year at school because of the baby. I’m not yet married and I

should not have had a baby and I really regret what I didI was very sad and it was very painful. I regretted more what I have done I brought an extra burden at home. My mother is not working, I'm not working and the man who made me pregnant rejected me.... I'm now a mother at the age of 20. Things that I liked doing I can't do now. Now I have to be always at home taking care of the baby, I'm not even going to school now" (Participant 05).

These findings are similar to those of Parekh and de la Rey (1997) who found that the transition to motherhood was accompanied by a number of psychological consequences that placed teenage mothers at risk regarding life adjustments. The fact that all the participants in this study experienced the confirmation of their pregnancy with a mixture of disbelief and disappointment suggests that they were far from emotionally, cognitively and socially ready for the prospect of motherhood.

4.1.4. A shift from traditional values

Participants expressed concern at the loss of traditional values due to cultural transition.

"....it is not right, it is not recommended for these medication to be used because we used those things and they were right. So now, when you give to these young generation and say use this, we also used it, they would say no it was used during your time not now and then you end up giving up to what they think is right, well it is their time....

I do believe strongly in Xhosa medicine but my children don't ...it does not feel right really, because it is really difficult to pass that knowledge to our children, even when you talk about life skills. You tell your child to do this but they do not sometimes do that. You get discouraged and you stop telling them but you never give up you use every

opportunity you get to pass the knowledge. It is very hurting because you think when we were still young whatever our parents told us we valued, we did exactly what they told us, we never questioned them, we respected their views. I always tell my children that you never listen to what we tell you and you do things your own way and look how things are now, what will happen is that they would pretend to be hearing but they would never do what they are told” (Participant 18).

“We as Xhosa people, you cannot be present during the time of childbirth that is for white people to do. As a Xhosa men you can only take your wife to hospital and when you are there you can get the hospital details so that you will find out what is happening but you cannot be present...it is just not allowed, this is a tradition, so I can’t go against it...It did not happen to our father, it won’t happen with us. I don’t know perhaps it is going to happen with this young generation they do things differently, they are educated and they want to live like whites” (Participant 17).

These quotes suggest a loss of hope that the knowledge they valued and believed in still has the same impact that it did for them. They emphasized that, within Xhosa culture, the passing down of knowledge to the next generation was regarded as one of the greatest values of the tradition, but the fear was that all that was getting lost due to changing life styles and acculturation. This raised feelings of sadness and loss in most of the participants. Within the Xhosa tradition, knowledge that was obtained from parents was valued as the absolute truth. However, this seems to have changed with the new generation. The loss of such a culture seems to resemble the loss of values within the Xhosa community.

Another issue that brings about a shift in traditional values is the involvement of men in the childbearing process. As one of the respondents, who believed men should be involved during the childbirth process, stated:

“because if they could be there to see how the baby comes, how do you feel when you give birth, I don’t think men would be doing what they are doing, ignoring their responsibilities and abusing us as women” (Participant 13).

Brindley (1985) and Setiloane (1988) have mentioned that men were not allowed even near the birthing place. The current situation of childbirth practices is that men are now allowed to be present during labour. Differing views were expressed regarding male involvement. Some participants for example expressed the need for males to be involved during the time of labour. Reasons given included the need to know what was happening, which was shared by men participants, and the need for men to witness the pain during birth. This was believed could help men take their paternal responsibility seriously.

Another view was that men should not be present during childbirth since this was private for women. *“I don’t like men coming during labour because we as women do not go to the mountain when they go for circumcision. So you see giving birth is a private thing for women... Men can know about it but they must not be there...that is a Xhosa tradition”* (Participant 13). Women compared childbirth to male circumcision in that women are not even allowed to talk about that tradition, and thus the same principle should apply to women during childbirth.

Another aspect of change in traditional values was the period of seclusion.

“You see, in our days we stayed 10 days in doors and other woman would be taking care of you. I don’t know about these children who are all over the place after giving birth. I even asked my granddaughter because she is the one who called to inform me that she has given birth. I was very surprised that she’s been to the phone10 days indoors that was the rule, these days they do not adhere to that at all.... With me I told her that she would have to stay in doors, she should not do any household chores for that 10 days but she had to wait until her baby finishes a month before she can start cooking for us. I would cook for her and do everything for her” (Participant 09).

All the participants in this study mentioned the need and the importance of this period. This seclusion has been described as a period for allowing women to recover and for the womb to heal. According to Setiloane (1988), during the period of confinement the mother and the child are kept inside the hut. The mother is then treated as a convalescent, tenderly cared for and fed on soft sorghum porridge.

Participants also noted a shift from traditional rules pertaining to the role of elder family members who are not given the same recognition as previously when it comes to childbearing issues. The information provided by elders was now questioned and often not adhered to:

“Because it is really difficult to pass that knowledge to our children, even when you talk about life skills. You tell your child to do this but they do not sometime do that. You get

discouraged and you stop telling them, but you never give up, you use every opportunity you get to pass on the knowledge. It is very hurting because you think when we were still young whatever our parents told us we valued, we did exactly what they told us, we never questioned them, we respected their views. I always tell my children that you never listen to what we tell you and you do things your own way and look how things are now, what will happen is that they would pretend to be hearing but they would never do what they are told" (Participant 16).

Brindley (1985) stated that many of the traditional observances of pregnancy were reinforced by the injunctions of old women. Within Zulu culture the old women would assist younger women in preparation for delivery and the whole family largely relied on her knowledge and experience. The old woman did most of the things including antenatal care. When the foetus began to move the old woman rubbed both breasts and then the whole stomach (Brindley, 1985). Maturity and old age within the Zulu culture were associated with purity and thus a linkage with ancestors. Thus the old woman was regarded as the key protector of the mother and the baby during the childbearing period.

A shift was also noted by participants in relation to respecting the culture. Participants emphasized that it was within the tradition and culture not to question the validity of the practice or belief that was said to be culturally based. This non-questioning attitude was regarded as a form of respect and obedience:

"I don't know if it ever did happen, as I said earlier on we were very obedient, whatever we were told to do we would do without even asking. Even drinking cows milk was not

allowed, so you will have your tea black. It was also believed that if you did the cow will die” (Participant 03).

“The thing is it is the information that we know about and that comes from our ancestors, there has never been proof if those things are really happening but we believe they do because our grandparents would not have thought so if they were not there” (Participant 19).

A similar pattern was observed by Baartman (1983), where women could not give explanations for some of the practices they performed as it was tradition and they never asked why it needed to be done.

4.1.5. Communication task during the childbearing process.

In this category participants noted that the emphasis was placed on the aspect of “talking” about issues pertaining to childbirth. Firstly, during pregnancy the issue arises on who to inform about the pregnancy. Emphasis is placed on not revealing being pregnant in order to protect the baby and the mother from other people casting a spell:

“You must not tell of the duration of your pregnancy to other people, because if you do it will give them a chance to cast a spell, so people must just see with the baby or tummy growing big but even though do not tell the exact duration, you cannot let that kind of information get to people you might never know who are your enemies” (Participant 18).

This “not talking” was seen as a protective factor. This tradition has also been noted by other researchers (Baartman, 1983; Brindley, 1985; Chalmers, 1990).

Another form of “not talking” as a way of protecting oneself was by suppressing feelings and not talking about them, in order to avoid being seen as a failure or being ridiculed about your experiences:

“I told myself I would not make myself more vulnerable by telling other people I will hide it until I see how I can get myself out of the situation” (Participant 12).

This was also confirmed by one of the respondents who mentioned that not talking about feelings was something that was embedded within the Xhosa tradition. Talking about what you are experiencing could be regarded as a way of exposing your family to the outside world. Not talking was regarded as a form of trustworthiness and adhering to tradition.

However, there seemed to be another aspect of not talking which was seen as hindering the process of assisting during this childbearing process. As one of the respondents put it:

“Perhaps you will only be aware of depression during delivery but you find that they would not talk about it even if you try to talk about it.....you will find that most people suppress their feelings, this also happens with young mothers, no matter you try to talk to them about what you observe you will never get co-operation from them, the only response you will get is that everything is right” (Participant 15).

4.1.6. Conflicting practices

There also seemed to be a conflict between traditional ideologies about pregnancy and what should be done, and what the medical model indicated to be the correct way:

“Especially when they use Xhosa mixtures which are very strong, we usually encourage people not to use medication that is not prescribed by the doctor because we know that the doctor will prescribe something that is good for the baby. But you’ll find that women are more concerned that they want to protect themselves. There is one thing that I have seen that Xhosa people do believe strongly in their traditional medicine and that it protects them.... It is very irritating to inform people not to use medication that has not been prescribed by the doctor because it might be harmful to the baby and people would continue using such medications.... And as a nurse you end up not knowing what to do because these things are their belief and you could never remove that” (Participant 15).

Other participants mentioned preferring medical mixtures than traditional Xhosa mixtures. This they indicated relates to trusting the medical mixture to be safe. One participant stated “...at least if you get medication from the chemist, you know that what they have put in is safe and is in right quantities, it won’t harm the baby. You know these people who do Xhosa mixtures sometimes do their own things” (Participant 04).

One respondent mentioned not trusting such remedies because of fear of HIV, should the animals being used have the virus: *“Now we are scared of using those kinds of substances, because we don’t know if these things could also have a HIV or what other illnesses it can contribute to. Now a woman has to go to the doctor to be sure that everything is safe”* (Participant 04).

This relates to what Davis-Floyd and Sargent (1997) term authoritative knowledge, where one ideology dominates. Schott and Henley (1996) also describe this conflict of ideologies when they refer to good and bad patients; the tendency of the medical model to ascribe the good patient label to those who strictly adhere to the rules prescribed by this model, and the bad patient label to those who do not adhere to the rules.

Another form of change in practice was between what was referred to as traditional Xhosas and the urban Xhosas and their adherence to tradition:

“There are huge differences, people from the Eastern Cape still adhere to Xhosa tradition but people born in Cape Town do not know much about traditional things because it is not much practised here as it does at the Eastern Cape” (Participant 11).

A strong connection was made between the rural way of life as traditional and the urban way of life as not. When discussing tradition all respondents regarded the rural Eastern Cape, as the place to conduct their rituals. Further, when they refer to the Eastern Cape they said it was home or “emaXhoseni” (literally meaning a Xhosa area). This view of differences between the rural and urban perceptions amongst the Xhosa speaking persons was also reported by Drennan, Levett and Swartz (1991). They discussed the different perceptions of translation regarding ‘black’ person from the rural area and the ‘black’ person from the urban area. They found that their participants stated the view that a ‘true black’ person was a rural one, and that the urbanised black person was somebody in a state of transition and alienated from the natural state of black people. Baartman (1983) referred to a distinction between the westernised and the traditional Xhosa people. In her

study she included Xhosa women living in a rural area and referred to them as traditional Xhosa, as opposed to westernised Xhosa people living in a semi-urban area. Baartman (1983) also argued that there was a wide gap between the westernised and traditional Xhosa people; the westernised had drifted away from traditional practices which they regarded as irrelevant.

Another change noted by participants was the difference between Christian and cultural values. Most respondents referred to the baby as a gift from God, while referred to using traditional medicine as a form of interference with God's wishes:

"A child is a gift from God.....I don't believe in taking medicine when pregnant especially Xhosa medicine because I am a born again Christian" (Participant 3).

Mayer (1980) as cited in Baartman (1983) argued that the westernised Xhosa no longer showed intimate attachment to their old traditional lifestyle, because education and religion had made them question the value and meaning of some of their customs and traditions.

4.1.7. The positive impact of support

"A pregnant women needs to be taken care of and her needs must be attended to" (Participant 17).

"A woman should not come home and start getting involved with household chores after giving birth. It is very good to have someone who will assist her" (Participant 11).

"They need support mainly from their partners, care. There is that thing that men would not want to be with you when you are pregnant, like your man will be irritated with you."

That thing would definitely have an impact on you, it does not feel right. A pregnant woman should always feel loved and appreciated by her partner” (Participant 13).

Being taken care of is one of the important aspects of the pregnant woman’s needs. Brindley (1985) and Setiloane (1988) both mentioned the strength of support given to the childbearing woman. This is believed to act as a buffer to women experiencing stress during this process. Chalmers and Wolman (1993) reviewed studies on mother support during childbirth. They pointed out that positive support, encouragement and praise during the vulnerable period of labour and birth may have a positive effect on the mother’s feelings of value and competence; thus establishing a self-perpetuating cycle of confidence, competence and happiness in parenthood, and further facilitating positive relationships with baby and partner.

4.1.8. Paternal involvement

Participants spoke about the need for men to validate paternity before assuming their responsibilities as fathers:

“Sometimes they do not trust us as women, so when you are pregnant a man does not trust that it is really their children. Because it has happened that a woman would be made pregnant by another man but claims paternity of a different man” (Participant 11).

Both men and women in the study reported that men did not automatically attach to children unless they were certain that the child was theirs. Emphasis was placed on the issue of trust between partners. Some argued that paternity doubts happened mainly with

unmarried couples. Men mentioned that they would be willing to acknowledge the child if he or she shared the resemblance with them:

“Like my children need to have the same palm as mine, and if the baby’s is different then I could really doubt paternity, but then I would look for other thing that should resemble me” (Participant 17).

However, women participants argued that it was not mainly the issue of trust that made men not assume their responsibility, but rather that men were just not interested in being fathers. As one participant stated:

“I think it is just that sometimes men are selfish, they only think about what suits them” (Participant 14).

Another reason for men’s lack of involvement was the disappointment when the baby was not a boy. Men placed more emphasis on having baby boys as a sign of their family growth. The belief was that if you had baby girls your family will not grow, since girls would marry and have the children of another family:

“The reason is because the boy would increase my family whereas the girl will get married and then belong to other men’s family and give birth to children which increases that man’s family, so that is why men would mostly want boys” (Participant 17).

Another reason for lack of paternal involvement was immaturity, as one of the respondents stated:

“I think in most cases these boys are also young and not ready to become fathers” (Participant 04).

Participant 17 noted that most young fathers were still at school or unemployed and dependent on their families for support of the children. What was most important was that the traditional custom of reparation settlement was still adhered to by many families. This settlement would then guide the involvement of the father in the child's upbringing. Some of the participants stated that father involvement would be determined by this settlement. Parekh and de la Rey (1997) noted that this reparation settlement had an effect on the amount of support given by families.

The fourth aspect of father's lack of involvement was based on role definition. Participants believed that men who still adhered to old traditional patriarchal rules were less involved than those who were more liberal; *"I think they still have that old belief that a child is a woman's responsibility. Before everything was a woman's responsibility, taking care of the children, cleaning the house and cooking. So I think they still believe in those old ways of living"* (Participant 20). Most participants however reported being involved with child care activities.

4.1.9. Distress as source of an unsupportive community

All participants acknowledged that women experienced distress during the childbearing period:

"It could happen especially if there is no one concerned about you or supporting you. You then struggle on your own and feel lonely, and if you have everything you don't experience difficulties " (Participant 10).

"I should think when you are struggling and you try by all means to sort your things out but there is no success. I think it really impacts on people's emotional states. Because if everything is okay you would not have problems" (Participant 17).

This distress was not however associated with women having difficulty adjusting to the new role of parenting. Distress was rather associated with the failure of the women's environment to provide the necessary support in terms of caring and loving the woman.

Another important aspect was that participants used different words when explaining distress. Some respondents explained patterns of distress as *"not being right in the mind"* (Participant 17) and *"being emotional"* (Participant 10), also words such as *Uyaphambana* (you are mad) (Participant 03), *Uyaqhawukelwa* (something has gone missing) (Participant 11), *Unomvandedwa* (loneliness) (Participant 05) and *uyangihlukumeza* (being abused) (Participant 02) were used. "Stress" (Participant 13) was also mentioned. Swartz (1991) found that in African communities stress was seen as referring to agency external to the person. It has also been argued that there is no specific definition of mental illness amongst the Xhosa. Cheetham and Griffiths (1982) argued however that among rural African people only those patterns which constituted a threat to social cohesion and balance, such as disturbed behaviour and or extreme disturbances of expression and reason, were regarded as 'madness' and constitute mental illness. Ensink and Robertson (1994) found that patients and their families often used a combination of psychological and indigenous explanations for their experiences. They further noted how certain explanations drawing on indigenous and other sources of knowledge were

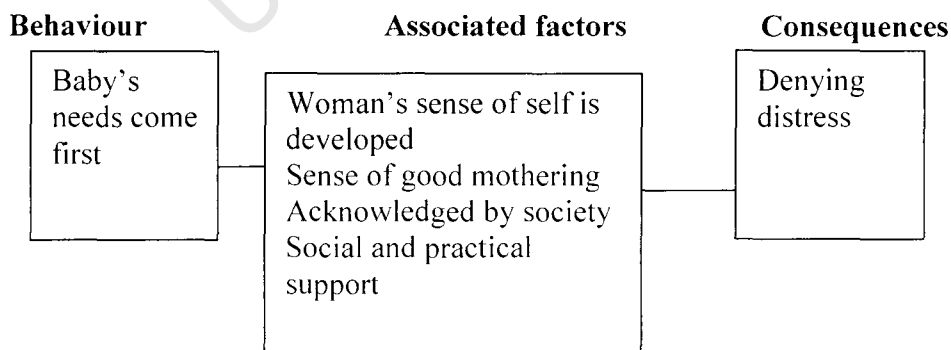
combined to construct meanings, and these did not fall neatly within the different categories of illness, either indigenous or psychiatric (cited in Kirk, 1996).

4.2. Hypotheses

Themes were carefully read and analysed for a central meaning, for example themes 5.1.1, 5.1.2, and 5.1.5 centred around the meaning of doing all that one needs to do to protect the baby. The importance of having a child was acknowledged to be so important that everything else came second. Childbearing defined living, and all the precautions mentioned were there to protect the baby. A central meaning that was extracted led to the formulation of a number of hypotheses:

4.2.1. Hypothesis 1

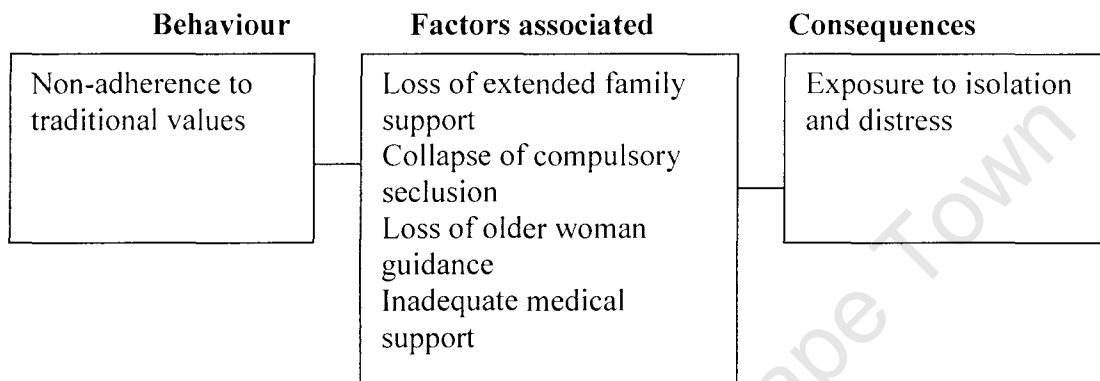
A trend within the Xhosa communities during pregnancy and the postpartum period to focus on the baby so that everything else becomes subordinate, could impact on how people experience their emotional states.



The most common feeling noted in theme 5.1.1, 5.1.2 and 5.15 was the acknowledgement that for every mother, whether pregnant or in the postpartum the baby's need came first. This seems to be associated with the ability of a woman to love the child. In the situation of a pregnant mother this prioritizing baby's needs is a process of ensuring that the baby would be delivered safely, and for the postpartum mother prioritizing the baby's needs brings a sense of achievement that a woman has carried a life to full term pregnancy. The survival of the baby out of the mother's womb depends on whether these needs are prioritized. When a mother prioritises the baby's needs, she is appreciated by the society and family as good mother. This is seen to define a role as a mother and a good woman. When it comes to distress and the possibility of the mother's needs interfering with the baby's needs, participants from the study mentioned that even under such circumstances a woman must focus on the baby's needs. Further there seemed to be an underlying assumption that a woman who may have difficulties taking care of baby's needs, will be failing her duties. This therefore led to the possibility that out of fear of being perceived as failing their duties, women may deny their feelings of distress. A similar perception was observed by Amankwaa (2003), where she argues that African-American women share a cultural belief that depression is regarded as a sign of weakness, an inability to handle responsibilities, and this was perceived to be a threat to their position or role of being a mother. Similarly A study conducted by Guerin-Weis (2000) as cited in Soet et al (2003) noted that could be a strong societal pressure on women to be happy with the birth of their baby, and to put the baby's health and needs before their own (Guerin-Weis, personal communication, December, 2000 cited in Soet, et al., 2003).

4.2.2. Hypothesis 2

The collapse of traditional values during the childbearing process may expose women to childbearing distress.



Themes 5.1.4 and 5.19 acknowledged that most of traditional family settings and values are no longer available. For example it was mentioned that extended family members were in the Eastern Cape. This therefore implies that the most valued traditional roles of extended family members such as older women's support was no longer available. The extended family support was acknowledged to be one of the supportive factors to women in the childbearing phase. The lack of such support appears to be seen as a factor exposing women to distress. Studies of Maimbolwa et al. (2003); Baartman (1983) and Chalmers (1990) supported the understanding that within the African communities, social support was a distinctive feature that protected a woman from distress. These studies also indicated the role of extended family in providing such support. For example, a study of Baartman (1983) mentions the appointment of one of family members as "umfukamisi" to care for the childbearing woman. Similarly Brindley (1985) also reported the significant role played by older woman during the childbearing person. It is however

important to note that the abovementioned studies were conducted within the rural communities where the extended family relationships seemed to be still adhered to. Participants in the study also mentioned the rural Eastern Cape as the place where they would have got more support and the place they use to conduct their rituals. Furthermore international studies of O'Hara (1986) and Webster et al. (2000) also confirms that lack of social support exposes woman to distress.

The non-adherence to the 10 day seclusion period was also perceived by participants to be exposing women to poor physical and mental recovery. As Baartman (1983) and Setiloane (1998), this seclusion period provided a woman to regain her health. This provided a woman with more practical and social support and caring for the baby was a shared experience. Furthermore the more reliability on medical personnel for support and guidance seem to be perceived as a factor exposing women to distress. As Chalmers (1990) states the exchange of psychological safety of the home and family for the medical safety of hospital and medical personnel promises better physical care of the mother and the baby, but less mental, emotional and spiritual care for motherhood.

4.2.3 Hypothesis 3

The absence of a common understanding of distress amongst African Xhosa speaking people may result in under diagnosing distress and inadequate support.

Behaviour

Different meanings of distress

Factors associated

Issues of cultural and familial relativity symptoms
Inadequate symptom recognition

Consequences

Under diagnosis and inadequate support

Theme 5.1.9. discuss the absence of a common understanding and common words defining distress. Participants used different words to identify the feelings of distress. Literature has also supported the perception that different expressions are used to describe distress. For example the studies of Ensink and Robertson (1994), Cheetham and Griffiths (1982) showed that different linguistics occurs in terms of diagnosis and understanding of mental illness. The distinctive feature was that the diagnostic perceptions draws upon indigenous knowledge and they are cultural specific. Unavailability of a common understanding may lead to people failing to acknowledge the experience of emotional distress. This may lead to under diagnosis and perhaps people may receive inadequate support in terms of people offering emotional and practical support, and also in terms of receiving proper medical support.

In summary the above noted three hypotheses indicated that within the Xhosa community adherence to traditional values has become less. This is seen to expose women to childbearing distress. However the lack of common understanding and definition of distress may lead to the symptoms being underreported and thus under diagnosed. Chalmers (1990) also notes that in terms of postpartum depression amongst South Africans the incidence may be under reported and perhaps not recognized.

CHAPTER 5: CONCLUSION

5.1. Conclusion

The study aimed to explore the perceptions and socio-cultural beliefs in relation to childbearing and the potential distress amongst African Xhosa speaking people in Cape Town. The purpose of this chapter is to describe the process that was followed in reaching the hypotheses.

The study suggests that amongst the African Xhosa speaking people there is wide variation in how women talk about issues of psychological distress. This view is similar to the findings of Robertson and Kottler (1993). Psychological distress seems to be understood in terms of severe mental illness, and thus influences people's perceptions of themselves and their response to mental illness. During the interview process, as the concept of distress was introduced, the participants often responded by saying "I am not stressed". The issue of mental illness among the African Xhosa speaking people and their perceptions of it has been discussed in detail by Cheetham and Cheetham (1976), Cheetham and Griffiths (1982), and Robertson and Kottler (1993). This therefore suggests that amongst the African Xhosa speaking people distress is often seen in a negative light, perhaps perceived as a form of weakness or losing control. This understanding has a negative impact on peoples' acceptance and acknowledgement of their experiences of distress.

Overall childbearing distress was perceived by participants to be associated with factors within the person's environment, so that if all necessary factors such as support within

the environment were available, distress would not be experienced. In the current study distress was described as a reaction to socio cultural shortcomings. This perception confirms a pattern described by De Villiers (1985) regarding illness, that within the African Xhosa nation, sickness is regarded as a result of misfortune or evil sent by other people. Similarly, Cheetham and Cheetham (1976) found that African Xhosa speaking people described illness in the context of socio cultural existence. The individual is not regarded as the source of distress; rather the environment exposes the individual to distress. A similar understanding was also observed by participants where the unavailability of financial, emotional and social support was described as a precipitant to the emotional instability of a childbearing woman. What seems more prominent within the responses was that none of the respondents attributed distress to the women's inability to adjust to motherhood. The nature of the unsupportive environment was further discussed by participants in relation to the transformation of socio cultural beliefs and practices. These are regarded as the cornerstones of Xhosa tradition and further believed to be there to protect and guide childbearing women to proceed through this phase of life smoothly. Participants mentioned that through urbanization and cultural transformation some of the traditional practices have been lost in African Xhosa speaking people, thus leaving women vulnerable to distress.

Three aspects of cultural transformation were mentioned. Firstly, the participants mentioned that the childbearing woman is exposed to distress due to a lack of extended family support. In the traditional extended family there were always women of the family available to provide assistance and support to the childbearing woman. After the delivery

a specific woman “*umfukamisi*” was assigned within the African Xhosa family to look after the needs of the childbearing woman (Baartman, 1983). Participants mentioned that this was one of the important features of the childbearing process that was no longer available. This suggests that childbearing women in urban areas may be more vulnerable to distress than those in rural extended families. Due to the current nature of smaller families, women have only their husbands available as a source of support. Participants in the current study mentioned that the support currently provided was not sufficient. They argued that a childbearing woman is fragile and needs support. There were however some limitations on how much the man could be part of the childbearing support. For example in the current study some respondents mentioned that men should be available for the whole process of childbearing process and whilst others mentioned that there should be limitation on men’s support, especially during the process of delivery, so that men should not be available. This issue of the effectiveness of the presence of men and the nature of the support required in this process needs further research.

Secondly, the participants discussed the role that was played by elder women of the family regarding guidance and provision of support to the childbearing woman. Brindley (1985) described the important role played by older women in the Zulu nation during the childbearing process, and a similar practice was observed by Baartman (1983). Participants in the study mentioned the importance of an old lady during the childbearing process, especially in providing guidance and support. The knowledge they acquired in the childbearing process was regarded as valuable and was passed down through generations. In this study it appeared that such a role has been replaced by medical

personnel at the clinic and hospitals, who are regarded as experts since they have trained and have the required skills. Having said this, although the medical personnel are considered skilled, they are perceived not to be present at all times to provide adequate support. Childbearing women in the current study reported to be adhering to the rules set out by medical personnel, but at the same time would take advice given by other experienced women, especially in situations where they believe medical personnel were not equipped to deal with the situation.

This study has shown that though traditional ideas about the childbearing process are still adhered to, they are being questioned. Nevertheless, participants said that they would not question many of the things they have been told to practice out of a form of respect given to older generation “*isiko alibuzwa*”.

Thirdly, traditional rituals and practices to protect childbearing women have diminished. The support and care that was provided during the antenatal period was no longer available. The observation of the ten day seclusion period, was no longer adhered to in the urban areas. This was regarded as a buffer to woman’s psychological wellbeing (Brindley, 1985; Setiloane, 1988). Another aspect was that most births happened in hospitals where women were discharged within hours of giving birth. This was regarded by participants to expose women to distress during the childbearing process. Social support was one of the important features of the childbearing process within the African Xhosa tradition.

Fourthly, central to all the responses was the emphasis on prioritizing the baby. For the childbearing woman, from the moment she is aware of pregnancy to the postpartum period, the baby's needs comes first. Participants mentioned that a childbearing woman must take care of the baby's needs before her own. This was perceived to be one of the important attributes that a mother should have. It is reflected as an indication of being a "good mother", as one of the respondents puts it " a good mother would take care of her child no matter what". Thus, even if a woman may feel some emotional instability, she needs to think about the baby first and focus on the baby's wellbeing. There is therefore a possibility that a mother might deny feelings of distress for the fear that she might be perceived to be not "a good mother".

Finally, the current study revealed that there was no one distinct explanation for mental illness and in particular distress that is used by African Xhosa speaking people. Some of the words given to describe distress were "*ukuphambana*", described by Ensink and Robertson (1996) as a negative possession state in which evil spirits and witch familiars possess the person, causing madness, and other words used were "*umvandedwa*" and "*ukuqhawukelwa*". Respondents in the study had different meanings for such conditions. They all mentioned however that this is a severe form of mental disturbance and was said not to be common amongst Xhosa childbearing women..

5.2. Limitations of the study

5.2.1. The validity and reliability of the study

Like most qualitative research the data cannot be generalized to the whole population, however it gives an understanding of the socio-cultural perceptions and beliefs in relation to childbearing distress amongst Xhosa speaking women in the Western Cape.

5.2.2. Analysis bias

Amankwaa (2000) discussed the use of peer reviewers to help the researcher in shaping the research process, by bringing insight to codes that the researcher might have overlooked. In the present study the biases of the researcher may have impacted to some extent on the analysis of the data, in the absence of others to challenge and confront these potentially problematic issues.

5.2.3. Objectivity of the research

As in most qualitative studies the researcher was not a silent observer, but rather a participant in the people's reality. Firstly, the identity of the researcher being a young African, Zulu speaking woman may have impacted on the research process. A noted trend from both the researcher and the respondents was the assumption that there was a shared understanding of concepts and beliefs. Secondly, the socio-economic status of the researcher, being a health professional might have had an impact on the responses given by respondents. It might have happened that respondents tried to make an impression by giving the perceived correct answers.

5.2.4. *Re-interviewing process*

Grounded theory suggests that if, after the initial analysis of the transcribed data, there are questions arising from the data that could give direction, the researcher may re-interview the participant to clarify the emerging codes (Glaser & Straus, 1967). Owing to the limited scope of the current research and the time frame involved, there was no time to re-interview the participants to confirm the emerging themes.

5.3. Final thoughts

I initiated the study with the aim of developing a theory of socio-cultural beliefs and patterns of childbearing distress. However at the end of my study I found myself with more questions. Firstly from my own personal experience I was aware that within the African communities emotional distress is not discussed openly. There seem to be a common perception that emotional distress symbolizes a form of weakness. Further more words that define expression of feeling or emotion could have different meanings for different people. For example Drennan et al (1991) gave a good example of a Xhosa expression “*Khathazekile*” which could mean being worried, sad or depressed. Findings of the study indicated that there is still little communication in terms of distress in general and in particular childbearing distress.

The second aspect in my thoughts was the socio-economic status of my participants. I wondered if there would be any difficulties in differentiating between distress that is due to socio-economic status and distress that is due to psycho-social adjustment. I observed

in the responses of my participants that distress was explained more in relation to economic availability and support.

It appeared therefore that the aspect of psychological distress during the childbearing process would require further exploration by mental health workers, to be able to provide a service that combines both the needs of women and sensitivity to the cultural values attached to this process. Though traditional and medical views of distress have been explored, there is still no common meaning attached to this phenomenon. Perhaps this calls for more studies to be conducted, with the aim of arriving at a common definition of psychological distress among Xhosa speaking women during the childbearing process. Such a definition would be useful to both medical and traditional health professionals during the assessment of potential distress during the childbearing process.

In conclusion, the current study serves as an initial exploration of potential distress in the childbearing process. Using the grounded theory method provided the participants with an opportunity to be able to express their experiences and to relate such experiences to psycho-social influences. It also provided the researcher the opportunity to be able to relate to the participants' insider information. Further studies will help in providing more knowledge on perinatal distress among the Xhosa speaking community

5.3.1. Future research

The following questions may be used for further study:

1. Childbearing is defined as an important task in a woman's life, a task that defines the sense of being a woman. There is however no indication on what is the current situation, where women are also expected to be working? What could be the available support? What role could the older woman play during the childbearing process?
2. The importance for the pregnant woman to protect the baby and the rituals they have to follow protecting the baby, led me to wonder about what happens in circumstances where the baby does not survive. Is there someone who gets to be blamed for that?
3. Since it appears that the ten days of rest and having people taking care of a postpartum woman is no longer available, what has been the replacement? Is there a support structure available to women? How can one be created?
4. Regarding the interesting point of the umbilical cord as defining a sense of belonging, what has been the impact of the current experiences? Are people still adhering to that process to define themselves? How is the sense of belonging developed in the modern days?
5. A woman is encouraged to focus on the baby and ensure that the baby is safe. The role of the mother is defined as giving birth and raising a healthy baby. What happens to women who experience depression and are unable to focus on the baby. How are women viewed by their families and the community?

6. Understanding that all respondents mentioned how crucial support from the baby's father is, what is stopping fathers from giving this support? Also the issue of men's involvement during labour, how much of that is related to them giving support to the partner, and how much of this is about them gaining power during this period? As Chalmers (1990) stated, it is not clear who initially brought about exclusion, whether it was women who excluded men or men who excluded themselves.

University of Cape Town

CHAPTER 6: REFERENCES

- Abrahams, N., Jewkes, R., & Mvo, Z. (2002). Indigenous healing practices and self-medication amongst pregnant women in Cape Town, South Africa. *African Journal of Reproductive Health*, 6, 79-86.
- Amankwaa, L. C. (2000). Qualitative data analysis: Using NUD*IST 4 in a preliminary investigation of postpartum depression among African-American women. *The Qualitative Report*, 4, 297-316.
- Amankwaa, L. C. (2003). Postpartum depression, culture and African-American women. *Journal of Cultural Diversity*, 10, 23-28.
- Baartman, D. T. (1983). *Traditional and modern approaches to the health care of the pregnant women in Xhosa society*. Unpublished Masters Thesis, Department of Nursing Science, University of South Africa.
- Ballou, J. W. (1978). *The psychology of pregnancy: reconciliation and resolution*. USA: Lexington Books.
- Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). *Qualitative methods in psychology*. Bristol, U.S.A.: Open University Press.
- Beck, C. T. (1992). The lived experience of postpartum depression: A phenomenological study. *Nursing Research*, 41, 166-170.
- Brindley, M. (1985). Old women in Zulu culture: the old woman and childbirth. *South African Journal of Ethnology*, 8, 98-108.

Chalmers, B. (1990). *African birth: childbirth in cultural transition*. South Africa: Berev Publications.

Chan, S. W. C., Levy, V., Chung, T. K. H. & Lee, D. (2002). A qualitative study of the experiences of a group of Hong Kong Chinese women diagnosed with postnatal depression. *Journal of Advanced Nursing*, 39, 571-79.

Chamarz, K. (2000). Grounded Theory: Objectivists and constructivists methods. In N.K. Denzin & Y.S. Lincoln (Eds), *The handbook of qualitative research* (pp. 509-531). London: Sage Publications.

Cheetham, R. W. S. & Cheetham, R. J. (1976). Concepts of mental illness amongst the rural Xhosa people in South Africa. *Australian and New Zealand Journal of Psychiatry*, 10, 36-45.

Cheetham, R. W. S. & Griffiths, J. A. (1982). Sickness and medicine an African paradigm. *South African Medical Journal*, 62, 954-956.

Chenitz W. C. & Swanson J. M. (1986). *From practice to grounded theory: Qualitative research in nursing*. Menlo Park, CA: Addison-Wesley.

Cooper, P. J., Tomlinson, M., Swartz, L., Woolgar, M., Murray, L., & Molteno, C. (1999). Post-partum depression and the mother-infant relationship in a South African peri-urban settlement. *British Journal of Psychology*, 175, 554-558.

Davis-Floyd, R. E. & Sargent, C. F. (1997). *Childbirth and authoritative knowledge: cross cultural perspective*. Los Angeles: University of California Press.

Declercq, E. (1998). "Changing childbirth" in the United Kingdom: Lessons for U.S. health policy. *Journal of Health Politics, Policy and Law*, 23, 833-860.

De Villiers, S. (1985). Consideration of illness causation among some Xhosa-speaking people. *South African Journal of Ethnology*, 8, 48-52.

Drennan, G., Levett, A., & Swartz, L. (1991). Hidden dimensions of power and resistance in the translation process. A South African study. *Culture, Medicine & Psychiatry*, 15, 361-381.

Eaves, Y. D. (2001). A synthesis technique for grounded theory data analysis. *Journal of Advanced Nursing*, 35, 654-663.

Ebert, S. (2003). Midwifery: does American culture prevent better outcomes in childbirth? *Sociology 161: principles of sociology*.
<http://users.ipfw.edu/hollandd/Midwifery.htm>.

Edwards, R. (1993). An education in interviewing: Placing the researcher and the researched. In C. M. Renzetti & R. M. Lee (Eds), *Researching sensitive topics*. (pp. 181-196). Newbury Park, California: Sage Publication.

Ensink, K. & Robertson, B. (1996). Indigenous categories of distress and dysfunction in South African Xhosa children and adolescents as described by indigenous healers. *Transcultural Psychiatric Research Review*, 33, 137-168.

Fonn, S., Xaba, M., Tint, K., Conco, D. & Varkey, S. (1998). Maternal health services in South Africa: during the 10th anniversary of the WHO 'safe motherhood' initiative. *South African Medical Journal*, 88, 697-702.

Fouche, J. P., Heyns, P. M., Fourie, M. C., Schoon, M. G. & Bam, R. H. (1998). The psychological needs of African women in labour in western-orientated obstetrical care. *South African Journal of Psychology*, 28, 71-73.

Glaser, G. B. & Strauss, A. L. (1967). *The discovery of grounded theory: strategies for qualitative research*. London: Weidenfield and Nicholson.

Grussu, P., Quatraro, R. M. & Nasta, M. T. (2005). Profile of mood states and parental attitudes in motherhood: comparing women with planned and unplanned pregnancies. *Birth: Issues of Perinatal Care*, 32, 107-121.

Hallgren, A., Kihlgren, M. & Olsson, P. (2005). Ways of relating during childbirth: an ethical responsibility and challenge for midwives. *Nursing Ethics*, 12, 606-621.

Hedegaard, M., Henriksen, T.B., Sabroe, S. & Secher, N.J. (1993). Psychological distress in pregnancy and preterm delivery. *British Medical Journal*, 307, 234-239.

Hirst, J., Hewison, J., Dowswell, T., Baslington, H. & Warrilow, J. (1998). Antnatal care: what do women want? In S. Clement (Ed.), *Psychological perspectives on pregnancy and childbirth*. (p.27). London: Churchill-Livingstone.

Holdstock, T. L. (1979). Indigenous healing in South Africa: a neglected potential. *South African Journal of Psychology*, 9, 118-124.

Hopa, M., Simbayi, L. C. & Du Toit, C. D. (1998). Perceptions on intergration of traditional and western healing in the new South Africa. *South African Journal of Psychology*, 28, 8-15.

Imogie, A. O., Agwubike, E. O & Aluko, K. (2002). Assessing the role of traditional birth attendants (TBAs) in health care delivery in Edo state, Nigeria. *African Journal of Reproductive Health*, 6, 94-100.

Izugbara, C. O. & Ukwai, J. K. (2004). An intercept study of persons attending traditional birth homes in rural southeastern Nigeria. *Culture, Health & Sexuality*, 6, 101-114.

Kirk, J. (1996). *Psychiatric, traditional and other interpretations of ukuthwetyulwa: a witchcraft phenomenon in the Western Cape*. Unpublished Masters Thesis, Department of Psychology, University of Cape Town.

Madi, B. C., Sandall, J., Bennett, R., & MacLeod, C. (1999). Effects of female relative support in labour: a randomized controlled trial. *Birth: Issues in Perinatal Care*, 26, 4-8.

Maimbolwa, M., Ahmed, Y., Diwan, V., & Arvidson, A. R. (2003). Safe motherhood perspectives and social support for primigravidae women in Lusaka, Zambia. *African Journal of Reproductive Health*, 7, 29-40.

Martin, R. P. M. (2000). Commentary: assessing women's well-being and social and emotional needs in pregnancy and the postpartum period. *Birth: Issues in Perinatal Care*, 27, 102-103.

Nakajima, H. & Mayor, F. (1996). Culture and health. *World Health*, 9, 3.

Nicolson, P. (1998). *Postnatal depression: psychology, science and the transition to motherhood*. London: Routledge.

O'Hara, M. W. (1986). Social support, life events, and depression during pregnancy and the puerperium. *Archives of General Psychiatry*, 43, 569-573.

Okonofua, F. (2002). Traditional medicine and reproductive health in Africa. *African Journal of Reproductive Health*, 6, 7-12.

O'Mahony, D. & Steinberg, M. (1995). A population-based survey of obstetric practices among rural women in the Bizana district, Transkei. *South African Medical Journal*, 85, 1168-1171.

Parekh, A. & de la Rey, C. (1997). Intragroup accounts of teenage motherhood: a community based psychological perspective. *South African Journal of Psychology*, 27,

Paris, R. & Helson, R. (2002). Early mothering experience and personality change. *Journal of Family Psychology*, 16, 172-185.

Preston-Whyte, E. (1988, October). *Culture, context and behaviour: anthropological perspectives on fertility in Southern Africa*. Paper presented at the International Conference on Population Development in Southern Africa, Johannesburg.

Rice, P. L. (1999). What women say about their childbirth experiences: The case of Hmong women in Australia. *Journal of Reproductive and Infant Psychology*, 17, 237-252.

Robertson, B. A. & Kottler, A. (1993). Cultural issues in the psychiatric assessment of Xhosa children and adolescents. *South African Medical Journal*, 83, 207-208.

Sakalys, J. A. (2000). The political role of illness narratives. *Journal of Advanced Nursing*, 31, 1469-1475.

Schott, J. & Henley, A. (1996). *Culture, religion and childbearing in a multiracial society: A handbook for health professionals*. Oxford: Butterworth-Heinemann.

Setiloane, G. M. (1988). African views on birth. *Nursing RSA Verpleging*, 3, 43-45.

Shereshefsky, P. M., Plotsky, H., & Lockman, R. F. (1974). *Pregnancy adaptation: Psychological aspects of a first pregnancy and early postnatal adaptation*. New York: Raven Press.

Small, M. F. (1998). *Our babies, ourselves: how biology and culture shape the way we parent*. New York: Anchor Books.

Smit, J., Bekisnika, M., Ramkinsoon, A., Kunene, B., & Penn-Kekana, L. (2004). Reproductive health. In P. Ijumba, C. Day & A. Ntuli (Eds) *South African Health Review 2003/04* (pp. 69-82). Durban: Health Systems Trust.

Soet, J. E., Brack, G. A., & Dilorio, C. (2003). Prevalence and predictors of women's experience of psychological trauma during childbirth. *Birth: Issues in Perinatal Care*, 30, 36-46.

Space Time Research. (2006). Khayelitsha. <http://www.str.co.au>.

Strauss, A. & Corbin, J. (1990). *Basics of qualitative research: grounded theory procedures and techniques*. London: Sage.

Swartz, L. (1991). The reproduction of racism in South African mental health care. *South African Journal of Psychology*, 21, 240-246.

Telfer, M. L., Rowley, J. T., & Walraven, G. E. (2002). Experiences of mothers with antenatal, delivery and postpartum care in rural Gambia. *African Journal of Reproductive Health*, 6, 74-83.

Van Balen, F. & Bos, H. M. W. (2004). Infertility, culture, and psychology in worldwide perspective. *Journal of Reproductive and Infant Psychology*, 22, 245-247.

Van der Kooi, R & Theobald, S. (2006). Traditional medicine in late pregnancy and labour: perceptions of Kgaba remedies amongst the Tswana in South Africa. *Journal of Traditional, Complementary and Alternative Medicines*, 3, 11-22.

Varela, R. E., Vernberg, E. M., Sanchez-Sosa, J. J., Riveros, A., Mitchell, M., & Mashunkashey, J. (2004). Parenting style of Mexican, Mexican American, and Caucasian-Non-Hispanic families: social context and cultural influences. *Journal of Family Psychology*, 18, 651-657.

Waldenström, U., Borg, I., Ollson, B., Skold, M. & Wall, S. (1996). The childbirth experience: a study of 295 new mothers. *Birth: Issues of Perinatal Care*, 23, 144-153.

Warmelo, N. J. (1974). The classification of cultural groups. In W. D. Hammond-Tooke (Ed.), *The Bantu-speaking peoples of Southern Africa* (pp. 56-81). London: Routledge & Kegan Paul.

Webster, J., Linnane, J. W. J., Dibley, L. M., Hinson, J. K., Starrenburg, S. E., & Roberts, J. A. (2000). Measuring social support in pregnancy: can it be simple and meaningful. *Birth: Issues in Perinatal Care*, 27, 97-101.

Wheatley, S. (1998). Psychological support in pregnancy. In S. Clement (Ed.), *Psychological perspectives on pregnancy and childbirth*. (p45). London: Churchill-Livingstone

Woollett, A. & Parr, M. (1997). Psychological tasks for women and men in the postpartum. *Journal of Reproductive & Infant Psychology*, Vol.15, retrieved on 25/11/2005, Academic Search Premier.

APPENDIX 1

Questionnaire

IDENTIFYNG DETAILS

1. AGE:

2.NUMBER OF CHILDREN

NAME	DATE OF BIRTH	GENDER

3. LAST PREGNANCY

4. MARITAL STATUS

SINGLE	MARRIED	DIVORCED	WIDOWED
DATE	DATE	DATE	DATE

5. EDUATIONAL LEVEL

NONE	
PRIMARY (Sub A-Std 5)	
SECONDARY (Std 6-Std 10)	
TERTIARY	

6. CURRENT ACTIVITES:

Employed/ Unemployed

If unemployed, when was the last date of employment?

7. PLACE OF RESIDENCE

HOUSEHOLD COMPOSITION

How many people live in the house at present?

Bangaphi abantu abahlala nawe endlwini?

NUMBER	
--------	--

Does the father of the child live with the mother?

YES: NO:

If NO, where does he live?

.....

Does the father support the mother financially?

YES: NO:

If the father does support the mother financially, how much money does he provide per month?

.....

Does the father have a negative or a positive attitude towards the child?

NEGATIVE: POSITIVE:

Include the respondent herself on the table and list **ALL** the people living in the house from the oldest to the youngest. Zifake nawe kuluhlu lwabantu abantu abahlala nawe, ubadwelise, uqale komdala uyokhutsho komncinci.

NAME	AGE	SEX	RELATIONSHIP TO THE RESPONDENT	MARITAL STATUS	PERMANENT RESIDENT. IF NO. WHERE DO THEY LIVE NORMALLY
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

9.					
10.					

SECTION B

QUESTIONS RELATING TO PREGNANCY

1. Can you tell me about what happened when you found out you were pregnant?
2. When did you know?
3. How did you find out?
4. Who did you tell?
5. What thoughts went through your mind?
6. How did you feel at that time?
7. How are you feeling now?
8. How was the impact of your pregnancy on your life?
9. Did you prefer your child to be a boy or a girl, Why?
10. Were there any things that you were scared of/ fearing? What sort of things?

Questions relating to socio cultural influence during pregnancy

1. Did you receive any antenatal care? If so, what kind?
2. If you had a choice would you have preferred medical, traditional and spiritual or both?
3. Were there any kinds of things that you had to or had not to do? What were those things?
4. Were there any expectations or rules that you had to follow during this period?
5. Were these rules same for every women?
6. Did you eat differently when you were pregnant?
7. Were there things that you should not eat?
8. Did you work whilst pregnant?
9. How did the pregnancy impact on your lifestyle (friends, family relationships)?
10. How was your sexual relationship?
11. What are the main problems that a pregnant women can have? Severity, symptom, cause.
12. Have you or anyone you know experienced any of these? What happened and how were they resolved?
13. Do pregnant women experience the following: Evil eye, bewitchment, trouble with ancestors, spiritual problems, nervous problems.
Can you explain? Give an example.

Questions relating to social support

1. What help does a pregnant women need?
2. Who offered this help to you?
3. Can you trust, talk to and share your feelings with your husband

and partner? Ingaba umthembile umyeni wakho neqabane lakho.
Ubaxelele izinto ezikukhathazayo nezinye izinto?

QUESTIONS RELATING TO LABOUR AND BIRTH

1. Where did you give birth?
2. If you had a choice where would you have liked to be?
3. What kind of birth did you have?
4. Who was with you (family, friend, partner)? Who would you have preferred to be with?
5. Are there special things that happen during labour or things that you would like to take with you?
6. What happened with the placenta/umbilical cord after giving birth? What you would have liked to happen?
7. What were your main worries regarding the birth process?

QUESTIONS RELATING TO POSTPARTUM PERIOD

1. Where did you go after giving birth?
2. How long was it for you to recover?
3. Who was with you during that period?
4. What kind of help do you think you needed the most?
5. What do you think is best for a woman after she gives birth? Would your mother have had the same experience, have things changed, do you prefer the old or the new way?
6. Are there things you should not do? What are those things?
7. Did you have to eat special foods?
8. What might a woman be worried about after giving birth?
9. Is a woman at more risk of bewitchment, evil eye, ancestor problems, spiritual problems? Do you know of any women who had these problems?
10. Do women ever have problems with their minds after they gave birth (nervous, mental/emotion)
 - Can you tell me as many types of these kinds of problems as possible?
 - Which women have these problems?
 - When do they get these problems? Straight after birth? A few weeks later?
 - What is the name for the problem? What causes it?
 - What do they do about it?
 - What happens to these women?
 - What happens to the baby? Is it affected?
 - Do you know any women who had this type of problem?
 - Can you tell me about this?
11. I am going to describe an example of what might happen to a woman.

Vignettes:

(1) A woman from my home area gave birth two months ago. She is now always arguing with her husband and says she wishes she had never had her baby. She thinks that nobody helps her and that she can't manage on her own. She doesn't know what to do. Sometimes she just cries.

(2) Another woman who had a baby recently, used to be friendly, but since giving birth has become very withdrawn. She doesn't seem to notice things around her. She even doesn't remember to feed her baby or herself. Sometimes she says it would be better for everybody if she was dead.

- Have you heard of anybody experiencing this?
- What is it called? What causes it? What should the woman do? What will happen to her? Will she get better? What will her husband say?
- Is it common?

APPENDIX 2

An Agreement to Take Part in an Interview in the Study on Postnatal Depression.

Interviewer: Jabulisile Chonco

Topic: The perceptions and socio-cultural beliefs of Xhosa speaking people in relation to perinatal distress.

You are kindly requested to take part in a study looking at perceptions and socio-cultural beliefs in relation to perinatal distress. The study is conducted by a masters clinical psychology at the University of Cape Town. The interview will take about 45 minutes. You will be asked questions about your experiences of postnatal depression.

The information you share during the interview will be treated as private and confidential. No names will be mentioned in anyway. An audiotape recorder will be used during the interview process. After completing the study all the material and recorded tapes will be kept confidential at the University of Cape Town.

Taking part in this interview will not disadvantage you in anyway. You are not compelled to take part in the interview. It is also within your right to withdraw should you change your mind. You may take your time in thinking about taking part, I will be available to answer your questions in this regard.

Agreement

I.....have read the contents of the agreement and would like to take part in this interview. The aim and what is expected of me has been made clear. My signature serves as confirmation of my agreement.

Signature:

Date

Interviewer:

Date:

APPENDIX 3

Participants Demographics

Participant number	Category	Age	Marital Status
01	Father	31	Single
02	Pregnant mother	26	Married
03	Childbirth attendant (Female)	58	Divorced
04	Grandmother	50	Single
05	Postpartum mother	20	Single
06	Father	30	Married
07	Pregnant mother	19	Single
08	Childbirth attendant	39	Married
09	Grandmother	60	Married
10	Postpartum mother	35	Widowed
11	Postpartum mother	36	Married
12	Postpartum mother	33	Single
13	Pregnant mother	27	Married
14	Pregnant mother	29	Single
15	Childbirth attendant	35	Married
16	Father	20	Single
17	Father	44	Married
18	Grandmother	60	Married
19	Childbirth attendant	62	Married
20	Pregnant mother	31	Married